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# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07664 — 07653

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND; b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury; c. LENGTH OF STAY IN 1b: —; d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Md.; b. COUNTY: Wor.; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Stockton; d. STREET ADDRESS: —; e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: ANNIE; Middle: MAY; Last: Bailey

4. DATE OF DEATH: Month: May; Day: 17; Year: 1966

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 17 1966

9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months —; Days —; IF UNDER 24 HRS.: Hours 1; Min. 35

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): Wicomico County, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James W. Bailey

14. MOTHER'S MAIDEN NAME: Annie Thomas

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO

(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address: James W. Bailey, Stockton, Maryland

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Immature Birth (1 day)

776X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): ; DUE TO (c): ;

INTERVAL BETWEEN ONSET AND DEATH: Approx 1/2 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/17, 1966, to 5/17, 1966, that (I) (we) last saw the deceased alive on 5/17 1966, and that death occurred at 10 P M, from the causes and on the date stated above.

22a. SIGNATURE: Alfred C Kolls M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/18/66

22c. PHYSICIAN'S NAME (Type): ALFRED C. KOLLS, M.D.

22d. ADDRESS: Medical Center Salisbury Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5-20-1966

23c. NAME OF CEMETERY OR CREMATORY: GEORGETOWN CEMETERY

23d. LOCATION (City, town or county) (State): WORCESTER COUNTY, MARYLAND

24. FUNERAL DIRECTOR: Robert H. Watson — ADDRESS: Roanoke City, Md.

25a. REC'D BY REGISTRAR DATE: MAY 23 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 20M 1/65

6-220242

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07665 07654

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND: Md. — b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury — c. LENGTH OF STAY IN 1b: yrs — d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — e. STATE: Maryland — b. COUNTY: Wicomico — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar — 22-1 — d. STREET ADDRESS: R#3 Old Stage Road — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Noah — Middle: — Last: Baines

4. DATE OF DEATH: Month: May — Day: 22 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1885

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (County & State, or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unk

14. MOTHER'S MAIDEN NAME: unk.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Irene Baines — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Hemorrhage. — INTERVAL BETWEEN ONSET AND DEATH: 5 days

331X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive arteriosclerosis — 4 years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/19/66, 19__, to 5/22/66, 19__, that (I) (we) last saw the deceased alive on 5/21/66, 19__, and that death occurred at 4 a.m. M, from the causes and on the date stated above.

22a. SIGNATURE — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) — 22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: May 26-66 — 23c. NAME OF CEMETERY OR CREMATORY: Union Cem — 23d. LOCATION (City, town or county) (State): Delmar Md

24. FUNERAL DIRECTOR: Baker McWest — ADDRESS

25a. REC'D BY REGISTRAR DATE: MAY 31 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 2DM 1/65

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07666

## CERTIFICATE OF DEATH

07653

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury,
   c. LENGTH OF STAY IN 1b: 1335 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Somerset
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marumsco
   d. STREET ADDRESS: Rural
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Arthur; Middle: ; Last: Bowyer

4. DATE OF DEATH: Month: May; Day: 31; Year: 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH: Apr. 2, 1901

9. AGE (In years last birthday): 65 yrs.
   IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Marumsco Md.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Lit Bowyer

14. MOTHER'S MAIDEN NAME: Esther Hayward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address: Lovenia Bowyer — Marion Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hypertensive arteriosclerotic cardiovascular disease.
443 X
DUE TO (b):
DUE TO (c):
Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus and Cerebral thrombosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 10/4, 1962 A, to 5/31, 1966, that (I) (we) last saw the deceased alive on 5/31 1966, and that death occurred at 5:50 M, from the causes and on the date stated above.

22a. SIGNATURE: W Maldve M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. XX

22b. DATE SIGNED: 6/1/66

22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/4/66

23c. NAME OF CEMETERY OR CREMATORY: Asbury

23d. LOCATION (City, town or county) (State): Marumsco Md

24. FUNERAL DIRECTOR: Anthony E. Ward

ADDRESS: Crisfield Md

25a. REC'D BY REGISTRAR DATE: JUN 3 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07667 07656

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm in 1-D 5/23/66
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Pen.Gen.Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 506 Mitchell St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First KEITH Middle RODNEY Last BOYLES SR.

4. DATE OF DEATH: FRI. Month MAY Day 27th Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept.24/1910

9. AGE (In years last birthday): 55 yrs. IF UNDER 1 YEAR: Months 8 Days 03 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Engineer - Campbell Soup Co.

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Williamsport, Pa.

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: David Boyles

14. MOTHER'S MAIDEN NAME: Unk Little

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 173-09-9401

17. INFORMANT, Address: Mrs.Kathleen V.Boyles(Wife) 506 Mitchell St.Salisbury,Md.21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 1day
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Congestive heart failure

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 19 65 to 5/27, 1966, that (I) (we) last saw the deceased alive on 5/27 19 66, and that death occurred at APR-9:55A.M. M, from the causes and on the date stated above.

22a. SIGNATURE: Earl M. Beardsley M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: May ___/1966

22c. PHYSICIAN'S NAME (Type): Dr.Earl M.Beardsley

22d. ADDRESS: Maryland Ave. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 31/1966

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND

25a. REG'D BY REGISTRAR DATE: JUN 2 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07668

## CERTIFICATE OF DEATH

07657

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. STREET ADDRESS: 413 Washington St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Atwood — Last: Bozman

4. DATE OF DEATH: Month: May — Day: 20 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 21 1878

9. AGE (In years last birthday): 87 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Mnie, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Bozman

14. MOTHER'S MAIDEN NAME: Sarah Bozman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edgar Bozman — Address: Wilmington Del

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 4 days

331X

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized arteriosclerosis — ?
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-15, 1966, to 5-20, 1966, that (I) (we) last saw the deceased alive on 5-19 1966, and that death occurred at 4:45 PM, from the causes and on the date stated above.

22a. SIGNATURE: Robt McClure M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 20 May 66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Buried

23b. DATE THEREOF: 5/22/66

23c. NAME OF CEMETERY OR CREMATORY: Oriole Cemetery

23d. LOCATION (City, town or county) (State): Oriole Md.

24. FUNERAL DIRECTOR: Lewis R Wilson — ADDRESS: Princess Anne

25a. REC'D BY REGISTRAR DATE: MAY 23 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07669 07658

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 1021 Spring Avenue

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 1023 Spring Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MINA Middle HANNAH Last BRADLEY
4. DATE OF DEATH (F): Month MAY Day 13 Year 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: May 25/1891
9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR Months 11 Days 18 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Work
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Laurel, Delaware
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Marion J. Warrington
14. MOTHER'S MAIDEN NAME: Shanarah Nichols
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Unk (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 214-10-9964
17. INFORMANT Address: Mrs. William G. Melson-(Daughter) 1021 Spring Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignancy Generalized
151X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) Undifferentiated — probably
DUE TO (c) starting from Stomach
INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4/13, 1966, to 5/13, 1966, that (I) (we) last saw the deceased alive on 4/30/66, and that death occurred at 7:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Andrew C. Mitchell M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 16 /1966
22c. PHYSICIAN'S NAME (Type): Dr. Andrew C. Mitchell
22d. ADDRESS: Maryland Ave. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 16/1966
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAY 17 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

N/A

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07670 (M) 07659

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: MARYLAND — b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: R.F.D. LIBERTYTOWN
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: MARY — Middle: — Last: Brittingham

4. DATE OF DEATH: Month: May — Day: 5 — Year: 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH:
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (County & State, or foreign country):
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: TIMOTHY RAYNE
14. MOTHER'S MAIDEN NAME: MARTHA LEWIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: No
17. INFORMANT — Address: MRS. MARY REESE, SALISBURY, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Cerebrovascular hemorrhage | 5 days |
| 331X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) | Congestive heart failure | 8 days |
| DUE TO (c) | Degenerative heart disease | Unknown |

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 5/1, 1966, to 5/5, 1966, that (I) ~~(we)~~ last saw the deceased alive on 5/5 1966, and that death occurred at 7:30 P M, from the causes and on the date stated above.

22a. SIGNATURE: George H. Henning — M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 5/8/66
23c. NAME OF CEMETERY ~~OR CREMATORY~~: RIVERSIDE
23d. LOCATION (City, town or county) (State): BERLIN R.F.D. MD

24. FUNERAL DIRECTOR: Anna A. Burbage — ADDRESS: Berlin Md.
25a. REC'D BY REGISTRAR — DATE: MAY 10 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07671

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 3 Film G377 6/6/66 mh

07660

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): P.G. HOSPT. D.O.A.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Ocean City Road,
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

22-1

3. NAME OF DECEASED (Type or print): First Wade Middle Brittingham Last Brittingham
4. DATE OF DEATH: Month May Day 27th, Year 1966.

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 30.1882.
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months 8 Days 27
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland, U.S.A.
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Lemuel B. Brittingham
14. MOTHER'S MAIDEN NAME: Emma Rounds

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217-36-0110
17. INFORMANT: Mrs. Ethel P. Brittingham (Wife)
Address: Ocean City Road, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushed chest.
INTERVAL BETWEEN ONSET AND DEATH: Sudden

9121

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Driving tractor and backed into tree.
20c. TIME OF INJURY Month, Day, Year Hour a.m.: 3:45 P.M. 5-27-66
20d. INJURY OCCURRED While at work ☒ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Farm.
20f. (City or town) (County) (State): Salisbury Wicomico Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Reyer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
22. DATE SIGNED: 5-31-66
EXAMINER'S NAME (Type): Dr. Earl L. Reyer
Address (Street, city, town, or county): Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 30. 1966.
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery,
23d. LOCATION (City, town or county) (State): Salisbury, Maryland.

24. FUNERAL DIRECTOR: Holloway & Co.
ADDRESS: Salisbury, Maryland.
25a. REC'D BY REGISTRAR DATE: JUN 2 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR AISME (5)
5M 1/65

Dr. Earl L. Boyer

1

FOR STATE HEALTH DEPT

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07672

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07661

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
   d. STREET ADDRESS: 515 Douglas Place
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

80

3. NAME OF DECEASED (Type or print): First: SHELTON — Middle: — Last: BROWN

4. DATE OF DEATH: Month: 5-3-66 — Doy: — Year: 19

5. SEX: M

6. COLOR OR RACE: AA

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/14 1898

9. AGE (In years last birthday): 67 yrs. — IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Morris Brown

14. MOTHER'S MAIDEN NAME: Marian ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: William Brown Booth St. Salisbury Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sub-dural hematoma, left — INTERVAL BETWEEN ONSET AND DEATH: 2 mo.
983X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Involved in altercation.

20c. TIME OF INJURY Month, Doy, Yeor: Haur 3 p.m. 3-5-66 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.): Own home

20f. (City or town) (County) (Stote): Salisbury, Wicomico, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: 5-6-66

2

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/7/1966

23c. NAME OF CEMETERY OR CREMATORY: Mt Nebo

23d. LOCATION (City or Town) (County) (State): Nebo (Rural Delmar Del

24. FUNERAL DIRECTOR — ADDRESS: Christ F. Stewart Salis Md

25a. REC'D BY REGISTRAR DATE: MAY 13 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07673 — 07662?

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1941 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cambridge
d. STREET ADDRESS: 14 Pine St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rachel — Middle: P. — Last: Bryan

4. DATE OF DEATH: Month: May — Day: 11 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 17, 1886

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Laborer

11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Lucy Pinder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ---------

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Adolphsus Stanley, Linkwood, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia, right lung — INTERVAL BETWEEN ONSET AND DEATH: 2 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332 X
DUE TO (b): Recurrent cerebral thrombosis — Yrs. & 1 week
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/16, 19 61, to 5/11, 19 66, that (I) (we) last saw the deceased alive on 5/11 19 66, and that death occurred at 3:40 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W. Maldve — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/12/66

22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/16/66

23c. NAME OF CEMETERY OR CREMATORY: Waugh

23d. LOCATION (City, town or county) (State): Cambridge, Md.

24. FUNERAL DIRECTOR: Julius C. Hollis

ADDRESS: Cambridge, Md.

25a. REC'D BY REGISTRAR DATE: MAY 24 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07674 07664

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City
d. STREET ADDRESS: [illegible]
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Mayme — Middle Timmons — Last Bunting
4. DATE OF DEATH: Month May — Day 23 — Year 1966
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☒
8. DATE OF BIRTH: Nov. 25, 1884
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Telephone Op.
11. BIRTHPLACE (County & State, or foreign country): Georgetown Del
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Borden L. Timmons
14. MOTHER'S MAIDEN NAME: Sarah Brittingham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 216-09-6286
17. INFORMANT: Mr. Harry T. Bunting — Address: Salisbury Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] — INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Pulmonary Edema
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1962, 19__, to 5/23, 1966, that (I) (we) last saw the deceased alive on 5/23/66 19__, and that death occurred at 11¾ M, from the causes and on the date stated above.

22a. SIGNATURE: A. C. Mitchell M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/24/66
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/26/66
23c. NAME OF CEMETERY OR CREMATORY: Evergreen
23d. LOCATION (City, town or county) (State): Berlin Md

24. FUNERAL DIRECTOR — ADDRESS: Anna A. Burbage Berlin Md
25a. REC'D BY REGISTRAR DATE: MAY 27 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
20M 1/65

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07675 Item 3 Film G377 - 6/6/66 mh 07665

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: yrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Dorset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eldmor Rte 4 46-3
d. STREET ADDRESS: 107 Park Ct
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Sara — Middle: — Last: Bynum
4. DATE OF DEATH: Month: May — Day: 23 — Year: 1966
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: 12-23-93
9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (County & State, or foreign country): D.C
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Link
14. MOTHER'S MAIDEN NAME: Emma
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Samuel Bynum — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardio Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 5 days
443 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive Cardio-Vascular Disease — 8 years
DUE TO (c): Hypertension — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. / p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-14-, 1966, to May 23, 1966, that (I) (we) last saw the deceased alive on May 23, 1966, and that death occurred at 3 P M, from the causes and on the date stated above.

22a. SIGNATURE: G. Herbert Sembly — M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: 5/24/66
22c. PHYSICIAN'S NAME (Type): G. Herbert Sembly
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-28-66
23c. NAME OF CEMETERY OR CREMATORY: Loretto Cem
23d. LOCATION (City, town or county) (State): Loretto md.

24. FUNERAL DIRECTOR: Booker Mccoy — ADDRESS:
25a. REC'D BY REGISTRAR DATE: MAY 31 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07676 07666

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hebron
d. STREET ADDRESS: Railroad Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Eddie — Middle S. — Last Carter

4. DATE OF DEATH: Month May — Day 28 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 14/1883

9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months 9, Days 14 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Mill Worker

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Worcester Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Sampson Carter

14. MOTHER'S MAIDEN NAME: Sallie Blades

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-16-3668

17. INFORMANT: Mrs. Hazel Collins (Step-Daughter) — Address: Whayland Drive Hebron, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

337X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-27, 1966 to 5-28, 1966, that (I) (we) last saw the deceased alive on 5-28 1966 and that death occurred at 7:30 PM, from the causes and on the date stated above.

22a. SIGNATURE: William R. Ellis Jr. M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-28-66

22c. PHYSICIAN'S NAME (Type): Dr. Wilbur R. Ellis, Jr

22d. ADDRESS: Medical Center Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 31/1966

23c. NAME OF CEMETERY OR CREMATORY: Mt Olive Church Cem.

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JUN 2 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07677 07667

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 118 Days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ridgely
d. STREET ADDRESS: 05-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Gardner — Middle: Pernell — Last: Collins

4. DATE OF DEATH: Month: May — Day: 17 — Year: 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-25-1910

9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: FACTORY

11. BIRTHPLACE (County & State, or foreign country): Salisbury, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Hattie Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.: 213-18-5421

17. INFORMANT: Ivy Collins — Address: Ridgely, Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cor Pulmonale — INTERVAL BETWEEN ONSET AND DEATH: Hrs.

5271

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Chronic pulmonary emphysema — Yrs.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1/19, 1966, to 5/17, 1966, that (I) (we) last saw the deceased alive on 5/17 1966, and that death occurred at M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 5/17/66

22c. PHYSICIAN'S NAME (Type): C. F. Gutierrez-Garrido, M. D.

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 5--66 — 23c. NAME OF CEMETERY OR CREMATORY — 23d. LOCATION (City, town or county) (State): Denton, Md

24. FUNERAL DIRECTOR: James B. Nashell — ADDRESS: Easton Md.

25a. REC'D BY REGISTRAR DATE: MAY 20 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

M

07678

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07668

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 7 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galena
d. STREET ADDRESS: 14-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mamie — Middle: Jane — Last: Conner

4. DATE OF DEATH: Month: May — Day: 18 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November, 14, 1886

9. AGE (In years last birthday): 79 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Kent Co; Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas A. Conner

14. MOTHER'S MAIDEN NAME: Margaret Mullen

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No. (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 218-20-6573

17. INFORMANT — Address: Miss, Julia C. Conner, Galena, Md. 21635

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: --

4201

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Cardiovascular Disease — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral Thrombosis due to Arteriosclerosis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/11, 1966 p. to 5/18, 19 66, that (I) (we) last saw the deceased alive on 5/18 19 66, and that death occurred at 1:20 M, from the causes and on the date stated above.

22a. SIGNATURE: L. V. Maldve, M. D.

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/18/66

22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May, 21, 1966

23c. NAME OF CEMETERY OR CREMATORY: St. Dennis Cemetery

23d. LOCATION (City, town or county) (State): Galena, Kent Co; Md.

24. FUNERAL DIRECTOR — ADDRESS: Edward Kellow Millington, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 23 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07679 07669

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland 22.1
d. STREET ADDRESS: William Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle JOSEPH Last Craig
4. DATE OF DEATH: Month May Day 8 Year 1966
5. SEX: Male
6. COLOR OR RACE: white
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ Baby
8. DATE OF BIRTH: May 8/1966
9. AGE (In years last birthday): 0 yrs. IF UNDER 1 YEAR: Months 0 Days 0 IF UNDER 24 HRS.: Hours 12 Min. 56
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Terry Albert Craig
14. MOTHER'S MAIDEN NAME: Margaret Pauline Hearne
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT Address: Mr. Terry A. Craig (Father) William St Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Atelectasis — INTERVAL BETWEEN ONSET AND DEATH
7625
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Prematurity
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that death occurred at 11 A.M., from the causes and on the date stated above.

22a. SIGNATURE: W. C. Morgan M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 8/1966
22c. PHYSICIAN'S NAME (Type): Dr. William C. Morgan
22d. ADDRESS: Medical Center Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 10/1966
23c. NAME OF CEMETERY OR CREMATORY: Fruitland
23d. LOCATION (City, town or county) (State): Fruitland, Maryland

24. FUNERAL DIRECTOR ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAY 10 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

6-220261

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07680 07670

1 (M)

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Delaware — b. COUNTY: Sussex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel 41-3
d. STREET ADDRESS: Seventh St.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Rebecca — Middle: Jane — Last: Cropper
4. DATE OF DEATH: Month: May — Day: 2 — Year: 19 66
5. SEX: Female
6. COLOR OR RACE: W
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: Sept 27, 1910
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (County & State, or foreign country): Delaware
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Violetus Foskey
14. MOTHER'S MAIDEN NAME: Estella Nicholson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 222-03-2270
17. INFORMANT — Address: John B. Cropper, Laurel, Del.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: 1 month
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442X
DUE TO (b): Nephrosclerosis — 4 years
DUE TO (c): Hypertensive C.V. renal disease — 4 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Convulsions
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/28, 19 66, to 5/2, 19 66 that (I) (we) last saw the deceased alive on 5/1, 19 66, and that death occurred at 4:30 M, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/5/66
23c. NAME OF CEMETERY OR CREMATORY: Odd Fellows
23d. LOCATION (City, town or county) (State): Laurel Del.

24. FUNERAL DIRECTOR: H Dukes — ADDRESS: laurel, Del.
25a. REC'D BY REGISTRAR — DATE: MAY 9 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
15M 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07681 — 07671

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
e. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 226 Monticello Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First GEORGE — Middle ASBURY — Last Culver
4. DATE OF DEATH: Month May — Day 9 — Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: July 5/ 1903
9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months 10, Days 4 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Salesman- Soap & Chem. Co.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Bridgeville, Del.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Robert Allen Culver
14. MOTHER'S MAIDEN NAME: Bertha Mae Nichols
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 340-09-2048
17. INFORMANT: Mrs. Paulinr K. Culver (Wife) — Address: 226 Monticello Ave. Salisbury, Maryland 21801

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic coronary artery disease — 2 yrs.
DUE TO (c): 4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Cerebral Arterial Insufficiency.
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/8/, 1966, to 5/9/, 1966, that (I) (we) last saw the deceased alive on 5/9/ 1966 and that death occurred at 5 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 9, 1966
22c. PHYSICIAN'S NAME (Type): Dr. O. J. Burton
22d. ADDRESS: Medical Center Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 12/1966
23c. NAME OF CEMETERY OR CREMATORY: Bridgeville Cem.
23d. LOCATION (City, town or county) (State): Bridgeville, Delaware

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND
25a. REG'D BY REGISTRAR — DATE: MAY 12 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in part II, Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07682

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07672

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: DOA
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   a. STATE: Delaware
   b. COUNTY: Sussex
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
   d. STREET ADDRESS: 523 W. 7th St.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

46.3

99

3. NAME OF DECEASED (Type or print): First ALBERT; Middle JAMES; Last CUSTIS

4. DATE OF DEATH: Month 5-18-66; Day; Year 19

5. SEX: Male

6. COLOR OR RACE: AA

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3-20-17

9. AGE (In years last birthday): 49 yrs.

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Day Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Marvil Package Co.

11. BIRTHPLACE (State or foreign country): Hallwood, Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GEorge Custis

14. MOTHER'S MAIDEN NAME: Daisy White

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 221-05-5107

17. INFORMANT Address: Emogene E. Custis, Laurel, Delaware

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bullet wound of brain — INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO (b):

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

981 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

2

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Shot during altercation.

20c. TIME OF INJURY Month, Day, Year: Hour 2:15 p.m. 5-18-66

20d. INJURY OCCURRED While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Marvil Package Co.

20f. (City or town) (County) (State): Hebron, Wicomico, Maryland

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

2

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Earl L. Royer, M.D. M.D.

409 Camden Ave., Salisbury, Md. Address (Street, city, town, or county)

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: May 19, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 23, 1966

23c. NAME OF CEMETERY OR CREMATORY: New Zion Cemetery

23d. LOCATION (City or Town) (County) (State): Laurel, Delaware

24. FUNERAL DIRECTOR: J. J. Frampton and Son ADDRESS: Federalsburg, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 25 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07683 Items 8,9,7 film 6376 5/20/66 mh 07673

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: DELAWARE — b. COUNTY: SUSSEX
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OCEAN VIEW 46-3
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARA — Middle M. — Last DAISEY

4. DATE OF DEATH: Month MAY — Day 2 — Year 1966

5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Mar. 9, 1894
9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): DELAWARE
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN E. DAISEY
14. MOTHER'S MAIDEN NAME: LUCY A. DAISEY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: 221-24-7866
17. INFORMANT: Address: VINA BENNETT, FRANKFORD, DEL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH:
4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic Heart Disease
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-30-, 19 66, to 5-2-, 19 66 that (I) (we) last saw the deceased alive on 5-2-19 66, and that death occurred at 10:50 M, from the causes and on the date stated above.

22a. SIGNATURE: James L. Cuffee M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/2/66
22c. PHYSICIAN'S NAME (Type):
22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 5-5-66
23c. NAME OF CEMETERY OR CREMATORY: MARINERS BETHEL
23d. LOCATION (City, town or county) (State): OCEAN VIEW, DELA.

24. FUNERAL DIRECTOR: A. Douglas Melson — ADDRESS: Frankford Del
25a. REC'D BY REGISTRAR DATE: MAY 12 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07684 07674

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 308 Locust Terrace

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury - Rural (Home Acres Farm) 22.1
d. STREET ADDRESS: R.D.#4
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First MAUDE Middle ELLEN Last DAVENPORT
4. DATE OF DEATH: Month MAY Day 23 rd Year 19 66
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Feb.10/1892
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR Months: 3 Days: 13 IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Worcester Co. Berlin, Maryland (Rural)
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Sampson Ayres Wimbrow
14. MOTHER'S MAIDEN NAME: Sarah Elizabeth Collins

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mr. David H. Wimbrow (Brother) Address: 106 West Locust Street Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intractable CHF — INTERVAL BETWEEN ONSET AND DEATH: 2 MON.
4221
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): ASCVD & severe cardiomegaly — YEARS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 5-18, 1962, to 5-21, 1966 that (I) (~~we~~) last saw the deceased alive on 5-21 1966, and that death occurred at 7:45 A.M., from the causes and on the date stated above. Add- 5-23-66

22a. SIGNATURE: Hubert R. White, Jr., M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: May 26/1966
22c. PHYSICIAN'S NAME (Type): Dr. Hubert R. White, Jr.
22d. ADDRESS: Fruitland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 26/1966
23c. NAME OF CEMETERY OR CREMATORY: Wimbrow & Ward Cemetery
23d. LOCATION (City, town or county) (State): R.D.#4 Salisbury, Md.

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR: MAY 31 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then (please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

N/A

# MARYLAND STATE DEPARTMENT OF HEALTH

**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

07685

## CERTIFICATE OF DEATH

07675

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. **PLACE OF DEATH**
   a. COUNTY: WICOMICO — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
   c. LENGTH OF STAY IN 1b: 20 YRS.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 926 E. Church st.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: MARYLAND
   b. COUNTY: WICOMICO
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
   d. STREET ADDRESS: 926 E. CHURCH ST
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: EDGAR — Middle: LITTLETON — Last: DENNIS

4. **DATE OF DEATH**: Month: MAY — Day: 27 — Year: 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 10, 1881

9. AGE (In years last birthday): 84 yrs.
   IF UNDER 1 YEAR: Months ____ Days ____
   IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CONTRACTOR

10b. KIND OF BUSINESS OR INDUSTRY: BUILDING

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARCELLUS DENNIS

14. MOTHER'S MAIDEN NAME: LAURA ANN POWELL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
    (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.: 220-32-8982

17. **INFORMANT**: MRS. HELEN HANCOCK — Address: SALISBURY, AMRYLAND

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:

4201

DUE TO (b): Arteriosclerotic Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 1955, 19..... to 5/27/66 19....., that (I) (we) last saw the deceased alive on 5/20/66 19....., and that death occurred at 8:50 PM, from the causes and on the date stated above.

22a. SIGNATURE: A.C. Mitchell M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/27/66

22c. PHYSICIAN'S NAME (Type): A.C. MITCHELL

22d. ADDRESS: MARYLAND AVE., SALISBURY, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5/30/1966

23c. NAME OF CEMETERY OR CREMATORY: WICOMICO MEM. PARK

23d. LOCATION (City, town or county) (State): SALISBURY, AMRYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: Dwight C. Hill Jr.

ADDRESS: SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JUN 1 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 5-63

1

FOR STATE HEALTH DEPT.

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**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (S)
6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07686

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07676

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 3 Days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico 22-1
d. STREET ADDRESS: Route 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARGARET Middle TRADER Last DICKERSON

4. DATE OF DEATH: Month 5 Day 11 Year 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 21, 1893

9. AGE (In years last birthday): 72 yrs.

IF UNDER 1 YEAR: Months ___ Days ___ IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Store Owner

10b. KIND OF BUSINESS OR INDUSTRY: Groceries

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Alfred Trader

14. MOTHER'S MAIDEN NAME: Mary Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: 220-52-7769

17. INFORMANT: Mrs. Mary E. Taylor, Same — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: Sudden
6 33 X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Arteriosclerotic cardio-vascular disease — Years
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Uterine bleeding due to endometrial hyperplasia. 2

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Cardiac arrest while under general anesthesia for D & C.

20c. TIME OF INJURY Month, Day, Year: Hour 1:04 p.m. 5-11-66 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Peninsula Gen. Hosp., Salisbury, Wic., Md.

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Earl L. Royer, M.D. M.D.
Earl L. Royer, M.D.
409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)

22. DATE SIGNED: May 13, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-15-1966

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Md.

24. FUNERAL DIRECTOR ADDRESS: Hill Funeral Home, Salisbury, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 16 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1 (M)

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07687

## CERTIFICATE OF DEATH

07677

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and from event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1 Wk.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. STREET ADDRESS: Blvd. Apartments
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

80

3. NAME OF DECEASED (Type or print): First LYDIA — Middle JOHNSON — Last DISHAROON

4. DATE OF DEATH: Month 5 — Day 27 — Year 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct. 21, 1895

9. AGE (In years last birthday): 70 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Andrew Johnson

14. MOTHER'S MAIDEN NAME: Hettie Ann Hitchens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): 0---

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Mrs. Thomas Irvins Address: Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): fibrillation — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs.
DUE TO
(b): Cardiac Insufficiency — 2 mos.
DUE TO
(c): Pneumonia — 3 days

4331

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify thot (I) (this hospital) attended the deceased from 5/1, 1966, to 5/27, 1966, thot (I) (we) last saw the deceased alive an 5/27 1966, and thot death occurred at 6:50 P M, from couses and on the date stated above.

22a. SIGNATURE: W. B. Smith M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: May 31, 1966

22c. PHYSICIAN'S NAME (Type): Dr. William B. Smith

22d. ADDRESS: S. Div. St. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-30-1966

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: Hill Funeral Home ADDRESS: Salisbury, Maryland

25a. REC'D BY REGISTRAR DATE: JUN 1 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07688 07688 07678

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 136 Upton Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22.1
d. STREET ADDRESS: 136 Upton Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM Middle WINFRED Last DIXON
4. DATE OF DEATH: Thur. Month MAY Day 19th Year 19 66
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 25/1892
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months 0 Days 24 — IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Salesman-Furniture, etc.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Wicomico Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: William Henry Dixon
14. MOTHER'S MAIDEN NAME: Octavia Sirman
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): W.W.#1 (Army)
16. SOCIAL SECURITY NO.: 214-10-9610
17. INFORMANT: Mrs. May T. Dixon (Wife) Address: 136 Upton Street Salisbury, Maryland 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Unk.
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized Arteriosclerosis — 5 yrs.
DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Apr 8 19 56 to 5/19, 19 66, that (I) (we) last saw the deceased alive on 5/19 19 66, and that death occurred at 8:00 P M, from the causes and on the date stated above.

22a. SIGNATURE: Earl Beardsley — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 20 /1966
22c. PHYSICIAN'S NAME (Type): Dr. Earl M. Beardsley
22d. ADDRESS: Maryland Ave. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 22/1966
23c. NAME OF CEMETERY OR CREMATORY: Shad Point Cemetery
23d. LOCATION (City, town or county) (State): Wicomico Co., Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAY 23 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07689 — 07679

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury, Maryland
c. LENGTH OF STAY IN 1b: 2 mo. 21days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wingate
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Nannie Middle E. Last Dunn

4. DATE OF DEATH: Month May Day 29 Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 27, 1884

9. AGE (In years last birthday): 81 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Dorchester Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Cusick

14. MOTHER'S MAIDEN NAME: Annie Tucker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service): - - -

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT Address: Mrs Phillip Todd, Cambridge, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): arteriosclerosis — 3
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3-8, 1966, to 5-29, 1966, that (I) (we) last saw the deceased alive on 5-29 1966, and that death occurred at 4A M, from the causes and on the date stated above.

22a. SIGNATURE: R. J. Gore M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-29-66

22c. PHYSICIAN'S NAME (Type): R. J. Gore, M.D.

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 31, 1966

23c. NAME OF CEMETERY OR CREMATORY: Cambridge Cemetery

23d. LOCATION (City, town or county) (State): Cambridge, Maryland

24. FUNERAL DIRECTOR ADDRESS: L. B. Compton Funeral Home Cambridge, Md.

25a. REC'D BY REGISTRAR DATE: MAY 31 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 2DM 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07690 07680

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico
d. STREET ADDRESS: R.F.D.#1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Evelyn — Middle: V — Last: Dutton

4. DATE OF DEATH: Month: May — Day: 16 — Year: 19 66

5. SEX: Female

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: March 5 1919

9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher School

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elbert Duckery

14. MOTHER'S MAIDEN NAME: Florence Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-20-0993

17. INFORMANT: Joseph Dutton Address: Quantico Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema secondary
171X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): to widespread pulmonary metastases
DUE TO (c): from carcinoma of cervix

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/13, 1966, to 5/16, 1966, that (I) (we) last saw the deceased alive on 5/13 1966, and that death occurred at 3:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: James L. Ewin M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED:

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/21/1966

23c. NAME OF CEMETERY OR CREMATORY: Church

23d. LOCATION (City, town or county) (State): Millington Md.

24. FUNERAL DIRECTOR: Clinton F. Stewart ADDRESS: Salis. Md.

25a. REC'D BY REGISTRAR DATE: MAY 20 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

0769 1 — 0768 1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 9 days.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MARDELA SPRINGS
d. STREET ADDRESS: 22-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ABNER Middle ROWE Last ELLIOTT
4. DATE OF DEATH: Month MAY Day 27 Year 1966
5. SEX: Male
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1-8-1883
9. AGE (In years last birthday): 82 yrs. — IF UNDER 1 YEAR: Months ___ Days ___ — IF UNDER 24 HRS.: Hours ___ Min. ___
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MERCHANT
10b. KIND OF BUSINESS OR INDUSTRY: GROCERY
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: JAMES P. ELLIOTT
14. MOTHER'S MAIDEN NAME: SARAH ELLIOTT
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: 214-34-7404A
17. INFORMANT: MARY ELLIOTT-MARDELA — Address: MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 332 ✗
DUE TO (b): Cerebral Arteriosclerosis
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Pneumonia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from MAY 18, 1966, to MAY 27, 1966, that (I) (~~we~~) last saw the deceased alive on MAY 27 1966, and that death occurred at 11:05 M, from the causes and on the date stated above.

22a. SIGNATURE: Thomas C. Hill Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: MAY 27, 1966
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS: Pine Bluff Road, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 5-30-66
23c. NAME OF CEMETERY OR ~~CREMATORY~~: MARDELA
23d. LOCATION (City, town or county) (State): MARDELA-SPRINGS MD.

24. FUNERAL DIRECTOR: Charles W. Mumford-Holmes Jr. — ADDRESS
25a. REC'D BY REGISTRAR — DATE: MAY 31 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
2DM 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07692 07682

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): (Rural) Salisbury 22-1
d. STREET ADDRESS: Rt. 2 Cedar Hurst Tr.Park
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: LEWIS Middle: PHENIX Last: ELLIOTT

4. DATE OF DEATH: Month: MAY Day: 28 Year: 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 21,1890

9. AGE (In years last birthday): 75 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fireman

10b. KIND OF BUSINESS OR INDUSTRY: Fire Company

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-01-8260

17. INFORMANT: Mrs. Mary E. Elliott Address: Route 2 Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intracerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 YEARS
331 X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral atherosclerosis — YEARS
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 5-13, 1966, to 5-28, 1966, that (I) (~~we~~) last saw the deceased alive on 5-28 1966, and that death occurred at 10 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Robert R. Thute, Jr. M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-28-66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-31-1966

23c. NAME OF CEMETERY OR CREMATORY: Dorchester Mem. Park

23d. LOCATION (City, town or county) (State): Cambridge, Md.

24. FUNERAL DIRECTOR: Thomas F. Wallace ADDRESS: Salisbury, Md.

25a. REC'D BY REGISTRAR DATE: MAY 31 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1 (M)

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07693

## CERTIFICATE OF DEATH

07683

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 14 R.
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital; Salisbury, Md

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Allen
d. STREET ADDRESS: 22-1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Louise; Middle: Eliza; Last: Elzey

4. DATE OF DEATH: Month: 5/2; Day; Year: 19 66

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Aug. 23, 1896

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W. WHAYLAND

14. MOTHER'S MAIDEN NAME: MARY HUFFINGTON

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: Wm Ed. Elzey
Address: Fruitland, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), end (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Hypertensive arteriosclerotic cardiovascular disease
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 3 weeks / Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Old recurrent cerebral thrombosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m.; 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from June 22, 19 65, to May 2, 1966, that (I) (we) last saw the deceased alive on 5/2, 1966, and that death occurred at 2:40 A.M., from the causes and on the date stated above.

22a. SIGNATURE: W. Maldve M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/2/66

22c. PHYSICIAN'S NAME (Type): L.V. Maldve, M.D.

22d. ADDRESS: Deer's Head State Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5/4/1966

23c. NAME OF CEMETERY OR CREMATORY: ALLEN CEM.

23d. LOCATION (City, town or county) (State): ALLEN, MD.

24. FUNERAL DIRECTOR ADDRESS: HILL FUN HOME, SALISBURY, MD

25a. REC'D BY REGISTRAR DATE: MAY 3 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

07694 07684

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WILLARDS
c. LENGTH OF STAY IN 1b: 73 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address)

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WILLARDS 22-1
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNIE Middle DENNIS Lost EVANS
4. DATE OF DEATH: Month MAY Day 9 Year 1966

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 6, 1892
9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME
11. BIRTHPLACE (County & State, or foreign country): WILLARDS MD RFD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: TEAMAN DENNIS
14. MOTHER'S MAIDEN NAME: LAURA SMITH

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.
17. INFORMANT: MR. JACOB EVANS Address: WILLARDS MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Chronic myocarditis
DUE TO (b): Cardiovascular renal disease
DUE TO (c): arteriosclerosis, hypertension
INTERVAL BETWEEN ONSET AND DEATH: 3yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 442 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1953, 19, to 5-9, 1966 that (I) (we) last saw the deceased alive on 5-9 1966, and that death occurred at 3:30 PM, from causes and on the date stated above.

22a. SIGNATURE: Frank Lewis — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-11-66.
22c. PHYSICIAN'S NAME (Type): Frank Lewis
22d. ADDRESS: Willards Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 5/12/66
23c. NAME OF CEMETERY OR CREMATORY: DENNIS-LEWIS
23d. LOCATION (City or Town) (County) (State): WILLARDS WIC. MD

24. FUNERAL DIRECTOR: Anna A. Burbage ADDRESS: Berlin Md
25a. RECD BY REGISTRAR DATE: MAY 16 1966
25b. REGISTRAR'S SIGNATURE: Jeanne Jones

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07695

## CERTIFICATE OF DEATH

07685

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 3 Hrs.
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
   e. STATE: Del. — b. COUNTY: Sussex
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millsboro 46-3
   d. STREET ADDRESS: R.D. 3
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Martha — Middle: H. — Last: Evans

4. DATE OF DEATH: Month: May — Day: 29 — Year: 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: May 8 1892

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Vacant Chicken

10b. KIND OF BUSINESS OR INDUSTRY: Vacant Ing

11. BIRTHPLACE (County & State, or foreign country): Del.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Mathew Pennell

14. MOTHER'S MAIDEN NAME: Rosetta Stephens

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no

(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 222-20-4515

17. INFORMANT: Harry Evans — Address: Millsboro Del.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: Few hrs.

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Hypertension

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 29, 1966 to May 29, 1966, that (I) (we) last saw the deceased alive on May 29, 1966, and that death occurred at 7 P.M., from the causes and on the date stated above.

22a. SIGNATURE: G. Herbert Sembly — M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: May 29, 1966

22c. PHYSICIAN'S NAME (Type): G. Herbert Sembly

22d. ADDRESS: Salisbury Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Millsboro Cemetery

23d. LOCATION (City, town or county) (State): Millsboro - Del.

24. FUNERAL DIRECTOR: Donald James — ADDRESS: Millsboro, Del.

25a. REC'D BY REGISTRAR: JUN 2 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07696

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07686

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street oddress): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission)
   a. STATE: Delaware — b. COUNTY: Sussex
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seaford 46-3
   d. STREET ADDRESS: 721 W. Ivy Drive
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First EUGENE — Middle VESTAL — Lost GASKIN

4. DATE OF DEATH: Month 5 — Doy 25 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-10-25

9. AGE (In yeors last birthday): 40 yrs.

IF UNDER 1 YEAR: Months / Doys — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): REGIONAL MANAGER

10b. KIND OF BUSINESS OR INDUSTRY: ABACUS CORP.

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LINDSAY GASKIN

14. MOTHER'S MAIDEN NAME: FLORENCE MILLARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) WAR II

16. SOCIAL SECURITY NO.: 213-20-0247

17. INFORMANT: DORETTA E. GASKIN — Address: SEAFORD DEL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia — INTERVAL BETWEEN ONSET AND DEATH: Minutes
DUE TO
(b): Mucous Obstruction of Trachea — Minutes
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
9227

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Sub mucous resection under local anesthesia 5-24-66

19. WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.): Patient aspirated mucous.

20c. TIME OF INJURY Month, Doy, Yeor: Hour 4:45 ☒ o.m. — 5-25-66 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Peninsula Gen. Hosp., Salisbury, Wic., Md.

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: May 26, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: MAY 28 1966

23c. NAME OF CEMETERY OR CREMATORY: ODD FELLOWS CEMETERY

23d. LOCATION (City or Town) (County) (State): SEAFORD DELAWARE

24. FUNERAL DIRECTOR: Watson Funeral Home, Seaford, Del.

ADDRESS:

25a. RECD BY REGISTRAR DATE: MAY 31 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07697 07687

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 40 Years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne, Md.
d. STREET ADDRESS: Route 2, Box 325
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First IRVIN — Middle ROBERT — Last GRANT

4. DATE OF DEATH: Month 5-27-66 — Day — Year 19

5. SEX: Male

6. COLOR OR RACE: AA

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 5/13/1906

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Labor

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): New York

12. CITIZEN OF WHAT COUNTRY: U SA

13. FATHER'S NAME: Irvin R. Grant

14. MOTHER'S MAIDEN NAME: Sadie Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): W II

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Irvin R Grant. III Princess Anne, Md

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Sub-arachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 8 hours
330X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Ruptured Berry Aneurysm — 6 hours
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: May 28, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/31/66
23c. NAME OF CEMETERY OR CREMATORY: John Wesley
23d. LOCATION (City or Town) (County) (State): Princess Anne, Md

24. FUNERAL DIRECTOR: William H. James Jr. — ADDRESS: Funeral Home, Princess Anne, Md.

25a. FILED BY REGISTRAR — DATE: JUN 2 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
6M 1/66

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
20 M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07698

## CERTIFICATE OF DEATH

07688

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 11 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 220 N. Sal. Blvd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JEAN; Middle LONG; Last GREEN

4. DATE OF DEATH: Month May; Day 22; Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Jan. 26,1920

9. AGE (In years last birthday): 46 yrs.

IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Walden Mezick

14. MOTHER'S MAIDEN NAME: Mary Long

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.
(If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Miss. Jaye Nottinghan , Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bilateral Pneumonia, post Operative — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Ruptured Duodenal Ulcer — 11 days
DUE TO (c): and peritonitis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
5410

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Strangulated Hernia — Operated
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/11/66, 19 to 5/22/66, 19 66; that (I) (we) last saw the deceased alive on 5/21/66, 19 66, and that death occurred at 1:55 A.M., from causes and on the date stated above.

22a. SIGNATURE: [signature]
M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/23/66
22c. PHYSICIAN'S NAME (Type): Oswald J. Burton, M.D.
22d. ADDRESS: Medical Center, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5-24-1966
23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
23d. LOCATION (City or Town) (County) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Hill Funeral Home Salisbury, Maryland

25a. REC'D BY REGISTRAR DATE: MAY 25 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07699 07689

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 636 Dover Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First HARRY — Middle JAMES — Last GUTHRIE

4. DATE OF DEATH: Month MAY — Day 8 — Year 1966

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 28/1909

9. AGE (In years last birthday): 56 yrs. — IF UNDER 1 YEAR: Months 08 Days 10 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee-Guard-Boat

10b. KIND OF BUSINESS OR INDUSTRY: Mfg. Co.

11. BIRTHPLACE (County & State, or foreign country): Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Alfred Elliott

14. MOTHER'S MAIDEN NAME: Daisy Guthrie

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. Lillian P. Guthrie (Wife) Address: 636 Dover St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure grade IV — INTERVAL BETWEEN ONSET AND DEATH: 3 days
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
7824

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/2, 1966 to 5/8, 1966, that (I) (we) last saw the deceased alive on 5/8 1966, and that death occurred at 7:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: W. B. Smith M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: 5/8/66

22c. PHYSICIAN'S NAME (Type): Dr. William B. Smith

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: May 11/1966 — 23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park — 23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR — DATE: MAY 10 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 2DM 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07700 07690

1. PLACE OF DEATH
a. COUNTY Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b 17 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tyaskin
d. STREET ADDRESS 22.1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First John Middle Last Hakemer
4. DATE OF DEATH Month May Day 23 Year 1966
5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5/30/1891
9. AGE (In years last birthday) 74 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Poland
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME Edward Hakemer
14. MOTHER'S MAIDEN NAME Unknown
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No
16. SOCIAL SECURITY NO. 220-12-1383A
17. INFORMANT Antonia Hakemer, Tyaskin, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary insufficiency
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) Emphysema - obstructive
DUE TO (c) Pneumonia - Recurrent
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ____, 19__, to ____, 19__, that (I) (we) last saw the deceased alive on ____, 19__, and that death occurred at 4:34 P.M., from the causes and on the date stated above.

22a. SIGNATURE Richard E. Hughes M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED 5/23/66
22c. PHYSICIAN'S NAME (Type) Richard E. Hughes
22d. ADDRESS Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 5/27/66
23c. NAME OF CEMETERY OR CREMATORY Allegany Mem. Park Cem.
23d. LOCATION (City, town or county) (State) McCandless Township Pa.
24. FUNERAL DIRECTOR ADDRESS C.W. Basil, Bivalve, Md.
25a. REC'D BY REGISTRAR DATE MAY 25 1966
25b. REGISTRAR'S SIGNATURE J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

1 (M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

0770 — 0769

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 215 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Berlin
d. STREET ADDRESS: WEST ST
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| Paul | | Hamilton | May | 2 | 19 66 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | | JAN. 19, 1884 | 82 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| MILK DEALER | MILK | BROOKLYN NY | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| WILLIAM M. HAMILTON | MARIE LOUISE FLORIMONT |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) | (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| No | No | 132-01-0457 | RECORDS (BIRTH) |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bilateral bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Malignant tumor of left parotid gland with left facial weakness

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|---|---|---|
| | | | |

21. I certify that (I) (this hospital) attended the deceased from 9/29, 19 65, to 5/2, 19 66, that (I) (we) last saw the deceased alive on 5/2 1966, and that death occurred at 10:00 A.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ — 22b. DATE SIGNED: 5/2/66

22c. PHYSICIAN'S NAME (Type): C.F. Gutierrez-Garrido, M.D. — 22d. ADDRESS: Deer's Head Hospital; Salisbury, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) |
|---|---|---|---|
| CREMATION | 5/4/66 | SILVER BROOK | WILMINGTON DEL |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Amos A. Burbage | Berlin Md | MAY 4 1966 | J. Charles Judge |

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07702 — 07692

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 1650
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury — 22-1
d. STREET ADDRESS: 605 W. Main St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles — Middle: H. — Last: Harris

4. DATE OF DEATH: Month: May — Day: 15 — Year: 19 66

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/25/98

9. AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Chicken Farm

11. BIRTHPLACE (County & State, or foreign country): OHIO

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Harris

14. MOTHER'S MAIDEN NAME: Lavania Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Unknown
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Deer's Head State Hospital Records — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute cor pulmonale — INTERVAL BETWEEN ONSET AND DEATH: Hours
4221
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cerebral thrombosis with right hemiparesis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 11/7, 19 61 to 5/15, 19 66, that (I) (we) last saw the deceased alive on 5/15, 19 66, and that death occurred at 7:15 M, from the causes and on the date stated above.

22a. SIGNATURE — M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/16/66

22c. PHYSICIAN'S NAME (Type): C. F. Gutierrez-Garrido, M.D.

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Removal

23b. DATE THEREOF: 5-18-66

23c. NAME OF CEMETERY OR CREMATORY: National Bd

23d. LOCATION (City, town or county) (State): Balto Md

24. FUNERAL DIRECTOR: Cooper M West — ADDRESS

25a. REC'D BY REGISTRAR — DATE: MAY 25 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07703 07693

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 108 West Vine Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HAROLD — Middle AUSTIN — Last HAWKINS

4. DATE OF DEATH: Month MAY — Day 17 — Year 1966

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Sept. 30 1887
9. AGE (In years last birthday): 78 yrs.
IF UNDER 1 YEAR: Months 7 Days 17 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired ~~Security Guard~~ Shirt Mfg.
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Salisbury, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Hawkins
14. MOTHER'S MAIDEN NAME: Mary Murphy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 161-01-4820
17. INFORMANT: Mrs. Zenobia C. Hawkins (Wife) — Address: 108 W. Vine St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemiplegia Shock — INTERVAL BETWEEN ONSET AND DEATH: 20 MIN'S
451X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Ruptured Abdominal Aneurysm — 2 Hrs
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 3/17, 1966, to 3/17, 1966, that (I) ~~(we)~~ last saw the deceased alive on 3/17 1966, and that death occurred at 1020 M, from the causes and on the date stated above.

22a. SIGNATURE: John M. Bloxom III M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/17/66
22c. PHYSICIAN'S NAME (Type): JOHN M. BLOXOM III
22d. ADDRESS: MEDICAL CENTER, SALISBURY, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 20/1966
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAY 23 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

x

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07704 07694

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH: a. COUNTY: Wicomico — MARYLAND; b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury; c. LENGTH OF STAY IN 1b:; d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission): a. STATE: Maryland; b. COUNTY: Wicomico; c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Quantico Md.; d. STREET ADDRESS: Rt #1 Box 242; e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: EVA; Middle:; Last: HUBBERT

4. DATE OF DEATH: Month: MAY; Day: 15; Year: 1966

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 9-6-1904

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Oakfield, Ga.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Charlie Bryant

14. MOTHER'S MAIDEN NAME: Minnie Perry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Charles Cowart Address: Quantico Rt #1 Box 214

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Hemorrhage
332 x
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Late

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Anemia

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/13, 1966, to 3/15, 1966, that (I) (we) last saw the deceased alive on 3/19, 1966, and that death occurred at 8 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Dolly Hardy M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/17/66.

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-21-66

23c. NAME OF CEMETERY OR CREMATORY: Head-of-the Creek

23d. LOCATION (City, town or county) (State): Quantico Md.

24. FUNERAL DIRECTOR: Loretta B. Jolley ADDRESS: Jersey Rd. Salis.

25a. REC'D BY REGISTRAR DATE: MAY 27 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07705 — 07695

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Life Time
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS: 19.2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Elizabeth — Middle — Last Jacobs
4. DATE OF DEATH: Month MAY — Day 2 — Year 1966
5. SEX: Female
6. COLOR OR RACE: Negro
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 3/30/1890
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Cook
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Sidney Mills
14. MOTHER'S MAIDEN NAME: Learh Hayward

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 219-07-6486
17. INFORMANT — Address: Sarah Dishroon. Princess Anne, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolism Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
4200
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-12, 1966 to 5-2, 1966 that (I) (we) last saw the deceased alive on 5-2 1966 and that death occurred at 9:45 P.M., from the causes and on the date stated above.

22a. SIGNATURE: W. R. Collier M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-2-66
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/8/66
23c. NAME OF CEMETERY OR CREMATORY: Christ M.E.
23d. LOCATION (City, town or county) (State): Coston Station, Maryland

24. FUNERAL DIRECTOR — ADDRESS: William H. James Jr. Princess Anne, Md
25a. REC'D BY REGISTRAR — DATE: MAY 9 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07706 07696

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 99 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Millington
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Steven Middle VERNON Last Johnson
4. DATE OF DEATH: Month May Day 12 Year 19 66
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: JAN. 18, 1887
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABOR
10b. KIND OF BUSINESS OR INDUSTRY: VARIOUS
11. BIRTHPLACE (County & State, or foreign country): KENT Co. Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN JOHNSON
14. MOTHER'S MAIDEN NAME: FANNIE (UNK)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
16. SOCIAL SECURITY NO.: 218-16-5914
17. INFORMANT: MRS. EMMA JOHNSON Address: MILLINGTON, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CA of esophagus — INTERVAL BETWEEN ONSET AND DEATH: 1 year
150X
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic cardiovascular disease
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Feb. 2, 19 66, to May 12, 19 66, that (I) (we) last saw the deceased alive on May 12 19 66, and that death occurred at 2:35 P.M. from the causes and on the date stated above.

22a. SIGNATURE: C.F. Gutierrez-Garrido M.D.
M.O. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 5/12/66
22c. PHYSICIAN'S NAME (Type): C.F.Gutierrez-Garrido, M.D.
22d. ADDRESS: Deer's Head Hospital; Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: 5/17/66
23c. NAME OF CEMETERY OR CREMATORY: HADAWAY CHAPEL CEM.
23d. LOCATION (City, town or county) (State): R.F.D. CHESTERTOWN Md

24. FUNERAL DIRECTOR: Kenneth Valley
ADDRESS: CHESTERTOWN Md
25a. REC'D BY REGISTRAR DATE: MAY 16 1966
25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07707 07697

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 114 Tilghman

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. STREET ADDRESS: 114 Tilghman St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle WILLIAM — Last JONES
4. DATE OF DEATH: Month May — Day 25 — Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 5/1872
9. AGE (In years last birthday): 93 yrs. — IF UNDER 1 YEAR: Months 11, Days 20 — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Lumber Mill Employee
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (County & State, or foreign country): Powellville, Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Elis Chester Jones
14. MOTHER'S MAIDEN NAME: Clarissa Richardson
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 214-10-9111
17. INFORMANT Address: Mrs. Hazel M. Jones (Wife) 114 Tilghman St. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Accident — INTERVAL BETWEEN ONSET AND DEATH: 72 hours
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral arteriosclerosis — Unknown
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 1, 1966 to 5/25, 1966, that (I) (we) last saw the deceased alive on 5/24 1966, and that death occurred at App. 5:20 A.M., from the causes and on the date stated above.

22a. SIGNATURE: George H. Henning M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: May 26/1966
22c. PHYSICIAN'S NAME (Type): Dr. George H. Henning
22d. ADDRESS: 222 N. Division St. Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 27/1966
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAY 31 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

N/A

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07708 — 07698

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Spring Hill Sanitarium

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 303 Middle Blvd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARION — Middle SLEMMONS — Last JONES

4. DATE OF DEATH: Month May — Day 7 — Year 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 28, 1876

9. AGE (In years last birthday): 89 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Refrigeration engineer

10b. KIND OF BUSINESS OR INDUSTRY: Engineering

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Francis P. Jones

14. MOTHER'S MAIDEN NAME: Edith Livingston

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 215-01-2570

17. INFORMANT: Mrs. Marion S. Jones, Address: 303 Middle Blvd., Salisbury, Md.

### MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia — INTERVAL BETWEEN ONSET AND DEATH: weeks
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Chronic pyelonephritis — months
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture, left hip

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☒ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Fell at home.

20c. TIME OF INJURY Month, Day, Year: Hour a.m. p.m. 1:25-66 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Own home.

20f. (City or town) (County) (State): Salisbury, Wicomico, Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

22. DATE SIGNED: May 9, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/10/1966

23c. NAME OF CEMETERY OR CREMATORY: Meadowridge Mem. Park

23d. LOCATION (City or Town) (County) (State): Howard County Md.

24. FUNERAL DIRECTOR ADDRESS: Thomas Wallace Salisbury, Md.

25a. REC'D BY REGISTRAR DATE: MAY 10 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07709 — 07699

## CERTIFICATE OF DEATH

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (if outside corporate limits, write RURAL, and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury — 22-1
   d. STREET ADDRESS: 216 Record Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle ALBERT — Last King JR.

4. DATE OF DEATH: Month May — Day 21 — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ (Baby)

8. DATE OF BIRTH: May 18/ 1966

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days 3 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Albert King

14. MOTHER'S MAIDEN NAME: Elizabeth Schultz

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SEGURITY NO.:

17. INFORMANT: Father — Address: (Same as above)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Subarachnoid hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

7605

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (b): Prematurity (Birthwt 17Yogms) See part II — 3 days

DUE TO (c):

PART II. OTHER SIGNIFIGANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): 1) Precipitrius delivery 2) Twin birth. This infant premature by wt only Other twin wt. 3220gms

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/18, 1966 to 5/21, 1966, that (I) (we) last saw the deceased alive on 5/21 1966, and that death occurred at 4:15 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Alfred C Kolls M.D. — ATTENDING PHYS. ☒ MED. DIREGTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5/21/66

22c. PHYSICIAN'S NAME (Type): Dr. A.C. Kolls

22d. ADDRESS: Medical Center Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 24/1966

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIREGTOR: HOILOWAY & COMPANY — ADDRESS: SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: MAY 26 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

6-220324

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07710 07700

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

**1. PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: Route 3, Walston Switch
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| WILLIAM | A. | LILLISTON | 5-18-66 | | 19 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | AA | MARRIED ☒ | 3-24-24 | 42 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Laborer | | Virginia | U.S.A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Charlie Lilliston | Anna Mae Satchel |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT (Address) |
|---|---|---|
| No | | Nettie Lilliston Rt. 3, Walston Switch Salis. Md. |

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|---|---|---|
| | | | |

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: May 19, 1966

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/22/66 | Green Acres Park | Salis. Wicomico Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Clinton Stewart | Clinton Stewart Salis. Md | MAY 26 1966 | Charles Judge |

VR A15ME (5) 6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07711 07701

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm in ID 4/28/66
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Pen.Gen.Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: R.D.#4 Snow Hill Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| MARY | ELLEN | LITTLETON | MAY | 2nd | 1966 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | | Jan.26/1892 | 74 yrs. | 03 | 06 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Retired-Employee-Laundry-Repair Dept. | | Eden, Maryland | U S A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George E.Jones | Annie E.Smullen |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| Unk | | Mr. Laurence F.Littleton (Husband) R.D.#4 Snow Hill Rd. Salisbury, Maryland |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Cerebral Thrombosis | Hour. |
| Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) | Generalized Arteriosclerosis | Yrs. |
| DUE TO (c) | | |

332X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

| 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
|---|---|
| | N/A |

| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|---|---|---|
| | | | |

21. I certify that (I) (this hospital) attended the deceased from 4/28, 1966 to 5/3, 1966, that (I) (we) last saw the deceased alive on 5/3 1966, and that death occurred at App-11:55p.m. from the causes and on the date stated above.

22a. SIGNATURE: M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: May. 3 /1966

22c. PHYSICIAN'S NAME (Type): Dr.Earl M.Beardsley — 22d. ADDRESS: Maryland Ave, Salisbury, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | May 5/1966 | Smullen Cemetery | Worcester Co., Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY & COMPANY SALISBURY, MARYLAND | MAY 5 1966 | Jeanes Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 20M 1/65

1

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be farworded to the Chief Medicol Examiner's Office along with form PM3. Page 5 moy be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used os o burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and (in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 7 Film G377 6/6/66 mh

07712

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07702

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest tawn): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in haspital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corparate limits, write RURAL and give nearest town): Ocean City
   d. STREET ADDRESS: 18th & Philadelphia Ave.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ~~BAGIO~~ BIAGIO Middle B Last MANCINI

4. DATE OF DEATH: Month 5 Day 26 Year 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 9, 1898

9. AGE (In years last birthday): 73 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Haurs / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NIGHT CLUB OWNER

10b. KIND OF BUSINESS OR INDUSTRY: SELF EMP

11. BIRTHPLACE (State or foreign country): NAPLES, ITALY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GABRIELLE MANCINI

14. MOTHER'S MAIDEN NAME: MARIA PACITA

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES (If yes give war or dates of service) YES

16. SOCIAL SECURITY NO. 217-03-6994

17. INFORMANT: Mr. GABRIEL MANCINI JR Address: OCEAN CITY MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
   PART I. DEATH WAS CAUSED BY:
   IMMEDIATE CAUSE (a): Ruptured aneurysm of the right common iliac artery — INTERVAL BETWEEN ONSET AND DEATH
   DUE TO
   Conditians, if any, which gave rise to immediate cause (a), stating the underlying couse last.
   (b)
   DUE TO
   (c)

   PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Haur a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factary, street, affice bldg., etc.)

20f. (City or tawn) (County) (State)

21. I certify that I took chorge of the remains described obove, held an Autapsy ☒, Inspectian ☒, Inquiry ☒, and in my apinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, tawn, or county): 409 Camden Ave., Salisbury, Md.

22. DATE SIGNED: May 28, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5/28/66

23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL

23d. LOCATION (City or Tawn) (County) (State): BERLIN Wor. Md.

24. FUNERAL DIRECTOR: Burbage Funeral Home, Berlin, Md.

ADDRESS

25a. REC'D BY REGISTRAR: DATE JUN 1 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 6M 1/66

1 M

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07713

## CERTIFICATE OF DEATH

07703

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Worcester
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ocean City — 23-2
   d. STREET ADDRESS: 8 N. 8th Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BERTRAM — Middle DRUMMOND — Last Mason

4. DATE OF DEATH: Month May — Day 11 — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11/30/84

9. AGE (In years last birthday): 81 yrs.
   IF UNDER 1 YEAR: Months — Days
   IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Marine Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Pennsy Railroad

11. BIRTHPLACE (County & State, or foreign country): Accomack Co., Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alvin H. Mason

14. MOTHER'S MAIDEN NAME: Willieanna Kellam

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs. Annie Mason Ocean City, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
   PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart Disease — INTERVAL BETWEEN ONSET AND DEATH: Unknown
   4200
   Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
   DUE TO (b):
   DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-11, 1966 to 5-11, 1966, that (I) (we) last saw the deceased alive on 5-11 1966 and that death occurred at 8:50 M, from the causes and on the date stated above.

22a. SIGNATURE: W. Ellis Jr. M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-13-66

22c. PHYSICIAN'S NAME (Type): Dr. Ellis, Jr.

22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/14/66

23c. NAME OF CEMETERY OR CREMATORY: Mt. Holly Cem.

23d. LOCATION (City, town or county) (State): Onancock, Virginia

24. FUNERAL DIRECTOR: John T. Williams — ADDRESS: Onancock, Va.

25a. REC'D BY REGISTRAR — DATE: MAY 16 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07714 07704

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 207 Ironshire, Snow Hill
d. STREET ADDRESS: 23-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Florence Middle H Last Mason

4. DATE OF DEATH: Month May Day 14 Year 1966

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 8 1892
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Home Furnishing Specialist
10b. KIND OF BUSINESS OR INDUSTRY: State
11. BIRTHPLACE (County & State, or foreign country): Worcester Co Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John L. Mason
14. MOTHER'S MAIDEN NAME: Julia Anne Ross

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: 217 36 1671
17. INFORMANT: Ralph L. Mason Sr. Address: Newark, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

| | | INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | Myocardial infarction | 10 hrs |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) | arteriosclerotic heart disease | 4 yrs |
| DUE TO (c) | generalized arteriosclerosis | 4 yrs |

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 14, 1966, to May 14, 1966, that (I) (we) last saw the deceased alive on May 14 1966, and that death occurred at 6:57 AM, from the causes and on the date stated above.

22a. SIGNATURE: John O Buckley M.D. ATTENDING PHYS. ☑ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-14-66
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 16 1966
23c. NAME OF CEMETERY ~~OR CREMATORY~~: Bates Methodist
23d. LOCATION (City, town or county) (State): Snow Hill Maryland

24. FUNERAL DIRECTOR: Truman E. Glenn ADDRESS: Snow Hill, Md.
25a. REC'D BY REGISTRAR DATE: MAY 16 1966
25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

1 (M)

**MARYLAND STATE DEPARTMENT OF HEALTH**
**Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

# CERTIFICATE OF DEATH

07715 07705

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

**1. PLACE OF DEATH**
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): SPRING HILL NURSING HOME

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WORCESTER
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BERLIN
d. STREET ADDRESS: RFD 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: MARY — Middle: — Last: MERCER

**4. DATE OF DEATH**: Month: MAY — Day: 10 — Year: 1966

**5. SEX**: F

**6. COLOR OR RACE**: W

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: MAY 5 1878

**9. AGE** (In years last birthday): 88 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): HOUSEWIFE

**10b. KIND OF BUSINESS OR INDUSTRY**: SELF

**11. BIRTHPLACE** (County & State, or foreign country): FREEPORT PA

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: JOSEPH ANTHONY

**14. MOTHER'S MAIDEN NAME**: JULIA ARNEL

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes give war or dates of service): No — No

**16. SOCIAL SECURITY NO.**: 275-30-1602

**17. INFORMANT**: Mrs. HILDA PATTERSON, Address SANTA BARBARA, CALIFORNIA

## MEDICAL CERTIFICATION

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiovascular renal disease
DUE TO (b):
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
442X
INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)**

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year, Hour o.m. p.m., 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from Oct, 1965, to 5-10, 1966 that (I) (we) last saw the deceased alive on 5-10 1966, and that death occurred at M, from causes and on the date stated above.

**22a. SIGNATURE**: Thomas Insley — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**

**22c. PHYSICIAN'S NAME** (Type): Phil G. R. Insley

**22d. ADDRESS**

**23a. BURIAL, CREMATION, REMOVAL** (Specify): BURIAL

**23b. DATE THEREOF**: 5/14/66

**23c. NAME OF CEMETERY OR CREMATORY**: SUNSET MEMORIAL PARK

**23d. LOCATION** (City or Town) (County) (State): BERLIN WOR MD

**24. FUNERAL DIRECTOR** — **ADDRESS**: Anne A. Burbage Berlin Md

**25a. REC'D BY REGISTRAR** DATE: MAY 16 1966

**25b. REGISTRAR'S SIGNATURE**: J. Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07716 07706

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury (Rural)
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Ridge -Rockawalking Road

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury (Rural) 22-1
d. STREET ADDRESS: Ridge-Rockawalking Road
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First ARTHUR Middle Q. Last MIDDLETON
4. DATE OF DEATH: Sun. Month MAY Day 15th Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: July 21/1886
9. AGE (In years last birthday): 79 yrs. IF UNDER 1 YEAR Months 9 Days 24 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Unk
11. BIRTHPLACE (County & State, or foreign country): Camden N.J.
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: William Middleton
14. MOTHER'S MAIDEN NAME: Amelia George
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Unk (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs. Dorothy Simmons (Step-Daughter) Address (Same as #2)

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: Yrs.
5271
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Cor pulmonale. — 5 yr.
DUE TO (c) Chronic pulmonary emphysema — 10 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Apr. 19 63, to 5/15 19 66, that (I) (we) last saw the deceased alive on 5/14 19 66, and that death occurred at 2:15 AM, from the causes and on the date stated above.

22a. SIGNATURE: Earl M Beardsley
M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: May 17/1966
22c. PHYSICIAN'S NAME (Type): Dr. Earl M. Beardsley
22d. ADDRESS: Maryland Ave. Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 18/1966
23c. NAME OF CEMETERY OR CREMATORY: Woodbury Mem. Park
23d. LOCATION (City, town or county) (State): Woodbury, New Jersey

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAY 17 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07717 Item 3 Film 0399 5/31/66 07707

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
e. STATE: Md.
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bishop 23-2
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First Henry Gance Middle Last Mumford

4. DATE OF DEATH: Month May Day 23 Year 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Oct 8, 1892

9. AGE (In years last birthday): 73 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Chicken Hatchery

11. BIRTHPLACE (County & State, or foreign country): Worcester Co, Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas W. Mumford

14. MOTHER'S MAIDEN NAME: Laura Daily

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 221-12-8415

17. INFORMANT: Rose Brown Address: Bishop, Md.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Myocardial Infarction 4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ASCVD.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Ca of lung

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-1- , 1966, to 5-20 , 1966, that (I) (we) last saw the deceased alive on 5-20 1966, and that death occurred at 7:30 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Joseph C. Fitzgerald M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-23-66.

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS: Medical Center, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 28, 1966

23c. NAME OF CEMETERY OR CREMATORY: Evergreen

23d. LOCATION (City, town or county) (State): Berlin Md.

24. FUNERAL DIRECTOR: Richard T. Watson ADDRESS: Selbyville, Del.

25a. REC'D BY REGISTRAR DATE: MAY 25 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Jones

VR A15 (4)
20M 1/65

Martha - Write on napkin -
Correct name is
Henry Dance? Mumford
Henry Gaines?
Henry James?

1

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07718

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07708

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Pen.Gen.Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 713 Howard Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| NORMAN | WILLIAM | NIBLETT | MAY | 26 | 1966 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | | May 11/1921 | 45 yrs. | 0 | 15 | | |

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Care Home Operator
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Joseph S.Niblett
14. MOTHER'S MAIDEN NAME: Georgia Hastings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes give war or dates of service): W.W.#II
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs.Antionett Niblett(Wife) Address: 713 Howard Street Salisbury,Md.21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Hours

4201

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Dr.Earl L.Royer
Address (Street, city, town, or county): 409 Camden Ave,Salisbury,Md.
22. DATE SIGNED: May 27/1966

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | May 29/1966 | Blades Cemetery | Blades,Delaware |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| HOLLOWAY & COMPANY | SALISBURY,MARYLAND | JUN 2 1966 | J.Charles Judge |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5)
5M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07719 07709

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 1501 Iris Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WALTER — Middle WILLIAM — Last OWENS
4. DATE OF DEATH: Month May — Day 20 — Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: June 28, 1901
9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired - Maintenance Employee
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Sussex Co., Delaware
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William E. Owens
14. MOTHER'S MAIDEN NAME: Fannie C. Carpenter
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
16. SOCIAL SECURITY NO.: 218-05-8991
17. INFORMANT: Mrs. Lola D. Owens, wife — Address: 1501 Iris Drive, Salisbury, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
4201
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22. DATE SIGNED: May 21, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 25, 1966
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Mem. Park
23d. LOCATION (City or Town) (County) (State): Salisbury, Wicomico, Md.
24. FUNERAL DIRECTOR — ADDRESS: Holloway & Company, Salisbury, Md.
25a. RECD BY REGISTRAR DATE: MAY 26 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07720 07710

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Willards
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): xx

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Willards
d. STREET ADDRESS: RFD
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

22-1

3. NAME OF DECEASED (Type or print): First: Harry — Middle: W. — Last: Palmer
4. DATE OF DEATH: Month: May — Day: 11 — Year: 1966 — 19
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: June 8, 1906
9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (County & State, or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Larry Palmer
14. MOTHER'S MAIDEN NAME: Lillie White
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Lillian Palmer — Address: Pittsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 10 minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Athero Sclerosis - Hypertension
DUE TO (c): Obesity
287X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
2Dc. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19
2Dd. INJURY OCCURRED While at work [ ] Not While at work [ ]
2De. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
2Df. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1950, 19__, to 5-11, 1966, that (I) (we) last saw the deceased alive on 5-11 1966, and that death occurred at 6:30 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Frank Lewis — M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type)
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 5/14/66
23c. NAME OF CEMETERY OR CREMATORY: Dennis
23d. LOCATION (City, town or county) (State): Willards, Md.

24. FUNERAL DIRECTOR: Peter Whaley — ADDRESS: Selbyville, Del.
25a. REC'D BY REGISTRAR: MAY 17 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07721 — 07711

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

**1. PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mardela
c. LENGTH OF STAY IN 1b: 1 Wk.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Maple Shade Nursing Home

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 2504 Ocean City Rd.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

**3. NAME OF DECEASED** (Type or print): First: EDNA — Middle: MELISSA — Last: PARKER

**4. DATE OF DEATH**: Month: 5 — Day: 3 — Year: 1966

**5. SEX**: Female

**6. COLOR OR RACE**: White

**7. MARRIED** ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

**8. DATE OF BIRTH**: Nov. 29, 1884

**9. AGE** (In years last birthday): 82 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): House Wife

**10b. KIND OF BUSINESS OR INDUSTRY**: Own Home

**11. BIRTHPLACE** (County & State, or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?**: U.S.A.

**13. FATHER'S NAME**: Daniel James Parsons

**14. MOTHER'S MAIDEN NAME**: Jane Layfield

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown): No — (If yes give war or dates of service): ---

**16. SOCIAL SECURITY NO.**: 216-01-5343

**17. INFORMANT** — Address: Miss. Lola J. Parker Same

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bleeding Gastric Ulcer — INTERVAL BETWEEN ONSET AND DEATH: 2
DUE TO (b): Partial Gastrectomy — 5 Weeks.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

5400

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

**19. WAS AUTOPSY PERFORMED?** YES ☐ NO ☐

MEDICAL CERTIFICATION

**20a. ACCIDENT WAS UNDERLYING** ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

**20b. DESCRIBE HOW INJURY OCCURRED.** (Enter nature of injury in Part I or Part II of item 18.)

**20c. TIME OF INJURY** Month, Day, Year — Hour a.m. p.m. — 19

**20d. INJURY OCCURRED** While at work ☐ Not While at work ☐

**20e. PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.)

**20f.** (City or town) (County) (State)

**21. I certify** that (I) (this hospital) attended the deceased from April 24, 1966, to May 2, 1966, that (I) ~~(we)~~ last saw the deceased alive on May 2 1966, and that death occurred at 5 A M, from causes and on the date stated above.

**22a. SIGNATURE**: H.S. Kuhlman — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

**22b. DATE SIGNED**: 5/3/66

**22c. PHYSICIAN'S NAME** (Type): Dr. H.S. Kuhlman

**22d. ADDRESS**: Sharptown, Maryland

**23a. BURIAL, CREMATION, REMOVAL** (Specify): Burial

**23b. DATE THEREOF**: 5-5-1966

**23c. NAME OF CEMETERY OR CREMATORY**: Parsonsburg Cemetery

**23d. LOCATION** (City or Town) (County) (State): Parsonsburg, Maryland

**24. FUNERAL DIRECTOR**: Hill Funeral Home — ADDRESS: Salisbury, Maryland

**25a. REC'D BY REGISTRAR** — DATE: MAY 5 1966

**25b. REGISTRAR'S SIGNATURE**: Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07722 07712

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worcester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Snow Hill 23-2
d. STREET ADDRESS: Route 2
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Edward Middle: Burton Last: Phillips
4. DATE OF DEATH: Month: May Day: 18 Year: 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]
8. DATE OF BIRTH: March 17/1916
9. AGE (In years last birthday): 50 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (County & State, or foreign country): Worcester Co., Maryland
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: Durand Phillips
14. MOTHER'S MAIDEN NAME: Mary Virginia Davis
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 212-10-7671
17. INFORMANT: Miss Lillian Mae Phillips (Sister) Address: R.D.# 2 Snow Hill, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction
4201
Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Atherosclerotic Heart Disease
DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH: 5-14-66

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work [ ] Not While at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-14, 1966, to 5-18, 1966 that (I) (we) last saw the deceased alive on 5-18-1966, and that death occurred at 5:4 M, from the causes and on the date stated above.

22a. SIGNATURE: James L. Clifford M.D. ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22b. DATE SIGNED: 5-18-66
22c. PHYSICIAN'S NAME (Type): Dr. James L. Clifford
22d. ADDRESS: Salisbury, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 21/1966
23c. NAME OF CEMETERY OR CREMATORY: Mt Zion Cemetery
23d. LOCATION (City, town or county) (State): Worcester Co., Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURY, MARYLAND
25a. REC'D BY REGISTRAR DATE: MAY 23 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

1

FOR STATE HEALTH DEPT.

M

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07723 — 07713

**1. PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route 50 & Naylor Mill Road

**2. USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Dorchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Vienna
d. STREET ADDRESS: Route 1, Box 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

00

**3. NAME OF DECEASED** (Type or print): First: EMERSON — Middle: HARRINGTON — Last: PINKETT, JR.

**4. DATE OF DEATH**: Month: 5 — Day: 12 — Year: 66 (19)

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | AA | | 9-27-41 | 24 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Day Laborer | Canning Factory | Cambridge, Maryland | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| Emerson H. Pinkett, Sr. | Martha E. Parker |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 212-40-9735 | Emerson H. Pinkett, Sr., Vienna, Maryland |

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushed skull — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

8164

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

| 20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
|---|---|
| | Passenger in auto involved in collision with another auto. |

| 20c. TIME OF INJURY Month, Day, Year Hour, a.m. | 20d. INJURY OCCURRED While at work ☐ Not While at work ☒ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|---|---|---|
| 12:45 5-12-66 | | Route 50 | Salisbury, Wicomico, Md. |

21. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer, M.D.
EXAMINER'S NAME (Type): Earl L. Royer, M.D.
Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: May 12, 1966

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 16, 1966 | Vienna Cemetery | Vienna, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| J. J. Frampton and Son, Federalsburg, Maryland — Jerome Frampton Jr. | MAY 23 1966 | Charles Judge |

VR A15ME (5) 6M 1/66

1

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07724

## CERTIFICATE OF DEATH

Items 11, 12, 13, 14 Film C329 7/27/66 mp

07714

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Worchester
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): W. Ocean City
d. STREET ADDRESS: 23-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Willie; Middle:; Last: Polk

4. DATE OF DEATH: Month: 5; Day: 2; Year: 1966

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-25-15

9. AGE (In years last birthday): 50 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? Unknown

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic carcinoma, stomach — INTERVAL BETWEEN ONSET AND DEATH:

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Severe dehydration
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-29, 1966, to 5-2, 1966, that (I) (we) last saw the deceased alive on 5-2 1966, and that death occurred at 405 PM, from the causes and on the date stated above.

22a. SIGNATURE: Francis A. Clark Jr. M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: 5-2-66

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. ~~BURIAL, CREMATION,~~ REMOVAL (Specify): 23b. DATE THEREOF: 5/4/66 — 23c. NAME OF CEMETERY OR CREMATORY: Greenmount Bury — 23d. LOCATION (City, town or county) (State): Baltimore Md.

24. FUNERAL DIRECTOR: Bosley Pratt — ADDRESS: Salisbury Md.

25a. REC'D BY REGISTRAR DATE MAY 5 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 4-64

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07725 07715

**1. PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): 924 S.Division Street

**2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)**
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. STREET ADDRESS: 924 S.Div.St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| JOSEPH | ELLIS | POPE | MAY | 1st | 1966 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | | Apr.13/1889 | 77 yrs. | 0 | 18 | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer - Retired - | Farming | Somerset Co., Maryland | U S A |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George Thomas Pope | Melvina Pusey |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 214-36-5762 | Mr. Samuel B.Pope (Son) 917 E.Church St Salisbury, Maryland |

**MEDICAL CERTIFICATION**

**18. CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cardiac decompensation — INTERVAL BETWEEN ONSET AND DEATH: 4 days

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last.
DUE TO (b): Asteriosclerotic heart disease — Years
DUE TO (c):

4200

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

| 20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) |
|---|---|
| | N/A |

| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|---|---|---|
| | | | |

21. I certify that (I) (this hospital) attended the deceased from 4-27 to 5-1, 1966, that (I) (we) last saw the deceased alive on 4-27 1966, and that death occurred at App. 1:07 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Hubert R. White, Jr. M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED: May 3 /1966

22c. PHYSICIAN'S NAME (Type): Dr. Hubert R. White, Jr. Dr. Robert T. Adkins — 22d. ADDRESS: Fruitland, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | May 3/1966 | Springhill Memory Gardens | Salisbury, Maryland |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HOLLOWAY & COMPANY SALISBURY, MARYLAND | MAY 5 1966 | J. Charles Judge |

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07726 07716

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. STREET ADDRESS: Quantico
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First GEORGE — Middle ERNEST — Last PRICE

4. DATE OF DEATH: Month MAY — Day 12 — Year 19 66

5. SEX: MALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/30/1890

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George Price

14. MOTHER'S MAIDEN NAME: Annie Goslee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mimmie Price Quantico, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aspiration Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: Days
5711
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Enterocolitis — 3 days
DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/13/66, 19__, to 5/13/66, 19__, that (I) (we) last saw the deceased alive on 5/13/66, 19__, and that death occurred at 4:05 P.M., from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. — ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/24/66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/15/66

23c. NAME OF CEMETERY OR CREMATORY: Quantico Cematory

23d. LOCATION (City, town or county) (State): Quantico, Maryland

24. FUNERAL DIRECTOR — ADDRESS: Clinton F. Stewart Sales

25a. REC'D BY REGISTRAR DATE: MAY 26 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07727 07717

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Accomack
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greenbackville 83-3
d. STREET ADDRESS: --
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CALLIE — Middle MAY — Last PRUITT

4. DATE OF DEATH: Month May — Day 2 — Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Sept. 26, 1878

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (County & State, or foreign country): Accomack County, Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Calvin McClary

14. MOTHER'S MAIDEN NAME: Sarah Young

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): --

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mrs J. Carroll Layfield, Address: Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Influenza. — INTERVAL BETWEEN ONSET AND DEATH: 4 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Generalized Debility
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan, 1966 to Apr., 1966 that (I) (we) last saw the deceased alive on May 2 1966, and that death occurred at ____M, from the causes and on the date stated above.

22a. SIGNATURE: David Ford M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): DAVID FORD — 22d. ADDRESS)

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 5-4-1966 — 23c. NAME OF CEMETERY OR CREMATORY: Union Greenbackville — 23d. LOCATION (City, town or county) (State): Worcester County, Md.

24. FUNERAL DIRECTOR: Robert H. Watson — ADDRESS: Pocomoke City, Md. — 25a. REC'D BY REGISTRAR DATE: MAY 5 1966 — 25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
15M 4-64

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07728 Item 9 Film G377 5/31/66 mh 07718

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL DR INSTITUTION (if not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 301 Maryland Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

22-1

3. NAME OF DECEASED (Type or print): First: Sewell; Middle: William; Last: Rayne

4. DATE OF DEATH: Month: May; Day: 21; Year: 19 66

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 9, 1893

9. AGE (In years last birthday): 72 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): GROCER

10b. KIND OF BUSINESS OR INDUSTRY: RETAIL

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: HENRY C. RAYNE

14. MOTHER'S MAIDEN NAME: SARAH B ELLE RAYNE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 291-14-0906

17. INFORMANT: MRS. S.W. RAYNE
Address: SAME

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Recurrent Cerebrovascular Accident
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 2 Days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from May 16 19 66 to May 21, 19 66, that (I) (we) last saw the deceased alive on May 21 19 66, and that death occurred at 4:20 P.M., from the causes and on the date stated above.

22a. SIGNATURE

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 5/23/66

22c. PHYSICIAN'S NAME (Type): C. F. Gutierrez-Garrido, M.D.

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5/24/1966

23c. NAME OF CEMETERY OR CREMATORY: WICOMICO MEM. PARK

23d. LOCATION (City, town or county) (State): SALISBURY, MARYLAND

24. FUNERAL DIRECTOR: HILL FUNERAL HOME
ADDRESS: SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: MAY 25 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

10 1 (M)

FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07729 — 07719

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Route #4, Springhill Road.

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   d. STREET ADDRESS: Route # 4. Springhill Rd.
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

22-1

3. NAME OF DECEASED (Type or print): First Margaret Middle Elizabeth Last Savage
4. DATE OF DEATH: Month May Day 10. Year 1966. 19
5. SEX: female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Jan. 20. 1921.
9. AGE (In years last birthday): 45 yrs.
   IF UNDER 1 YEAR: Months 3 Days 20
   IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Operator
10b. KIND OF BUSINESS OR INDUSTRY: Shirt Factory
11. BIRTHPLACE (State or foreign country): West Virginia.
12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: Charles OGrady
14. MOTHER'S MAIDEN NAME: Mary Margaret Parker
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
    (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT (Name and address): Mr. Robert K. Bratten(son) 3505 Sheppard St. Elpaso, Texas.

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumococcal meningitis — INTERVAL BETWEEN ONSET AND DEATH: Days

3401

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑
EXAMINER'S NAME (Type): DR. Earl L. Royer
Address (Street, city, town, or county): Salisbury, Md.
22. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: May 14.1966.
23c. NAME OF CEMETERY OR CREMATORY: Springhill Memory Gardens,
23d. LOCATION (City, town or county): R.D Salisbury, (State) Md.

24. FUNERAL DIRECTOR: Holloway & Co.
ADDRESS: Salisbury, Maryland.
25a. REC'D BY REGISTRAR DATE: MAY 17 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5) 5M 1/65

Dr. Paul L. Boyer

Item 18 Film 377 6-6-66 ams

1 FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07730

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07720

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): D.O.A. Pen.Gen.Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
d. STREET ADDRESS: 413 Barclay Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

22 / 99

3. NAME OF DECEASED (Type or print): First EDGAR Middle ISAAC Last SOMERS

4. DATE OF DEATH: Month MAY Day 31 Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: Feb.17/1901

9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Employee(Ice Co)Laborer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oriole, Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Capt. Isaac Somers

14. MOTHER'S MAIDEN NAME: Sarah Laird

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes.

(If yes give war or dates of service): W.W.#IIArmy

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Mrs.Richard A.Disharoon(Daughter) R.D.#3 Salisbury, Maryland 21801

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): [illegible] — INTERVAL BETWEEN ONSET AND DEATH: [illegible]

3220

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Acute alcoholism — Hours

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Chronic alcoholism

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

0

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: [signature] M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: June 7 1966

EXAMINER'S NAME (Type): Dr.Earl L.Royer

Address (Street, city, town, or county): 409 Camden Ave.Salisbury,Md.

2

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 3/1966

23c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY

ADDRESS: SALISBURY, MARYLAND

25a. REC'D BY REGISTRAR DATE: JUN 6 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1SME (5) 5M 1/65

1 M

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07731 07721

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland 22-1
d. STREET ADDRESS: Main Street,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Elizabeth Middle: Last: Stephens
4. DATE OF DEATH: Month: May Day: 11 Year: 19 66
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 23. 1881
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months: 2 Days: 18
IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: House work
11. BIRTHPLACE (County & State, or foreign country): Farmington, Delaware.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Masten
14. MOTHER'S MAIDEN NAME: Esther Smith
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service):
16. SOCIAL SECURITY NO.: 718-05-8685
17. INFORMANT: Mrs. Myrtle Elliott, Address: Main St. Fruitland, Maryland. Bo. Box 56

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Intracerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 days
331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral atherosclerosis — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 4-30, 1966 to 5-11, 1966, that (I) (we) last saw the deceased alive on 5-10 1966, and that death occurred at 2 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Hubert R. White, Jr., M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5-13-66
22c. PHYSICIAN'S NAME (Type): Dr. Hubert R. White Jr,
22d. ADDRESS: Fruitland, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May 14.1966.
23c. NAME OF CEMETERY OR CREMATORY: Wicomico Mem. Park.
23d. LOCATION (City, town or county) (State): Salisbury, Maryland.

24. FUNERAL DIRECTOR ADDRESS: Holloway & Co. Salisbury, Maryland.
25a. REC'D BY REGISTRAR DATE: MAY 17 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4) 20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07732 — 07728

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WICOMICO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne
d. STREET ADDRESS: 19-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEONA — Middle — Last STEVENSON

4. DATE OF DEATH: Month MAY — Day 29 — Year 1966

5. SEX: FEMALE

6. COLOR OR RACE: NEGRO

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/16/98

9. AGE (In years last birthday): 68 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: House Wife

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Benjamin Ballard

14. MOTHER'S MAIDEN NAME: Ellen Tilghman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Norman Stevnson, Princess Anne, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 day
332X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5-18, 1966 to 5-27, 1966 that (I) (we) last saw the deceased alive on 5-29, 1966 and that death occurred at 10 AM, from the causes and on the date stated above.

22a. SIGNATURE: [signature] M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 5-29-66

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 6/1/66

23c. NAME OF CEMETERY OR CREMATORY: John Wesley

23d. LOCATION (City, town or county) (State): Westover Maryland

24. FUNERAL DIRECTOR — ADDRESS: William H. James Jr. Princess Anne, Md

25a. REC'D BY REGISTRAR — DATE: JUN 1 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

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# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07733 07723

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: LIFE
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: DELAWARE b. COUNTY: SUSSEX ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SEAFORD 46-3
d. STREET ADDRESS: 530 N. PHILLIPS ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SCOTT Middle MICHAEL Last Stubblefield
4. DATE OF DEATH: Month May Day 17 Year 1966
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 17, 1966
9. AGE (In years last birthday): — yrs. IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours 8 Min. 42
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INFANT
10b. KIND OF BUSINESS OR INDUSTRY: INFANT
11. BIRTHPLACE (County & State, or foreign country): WICOMICO MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME: ROBERT ALLEN STUBBLEFIELD
14. MOTHER'S MAIDEN NAME: SYLVIA ITUMPHREYS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service): —
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT Address: ROBERT A. STUBBLEFIELD - SEAFORD, DEL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Brain damage — INTERVAL BETWEEN ONSET AND DEATH: 5 hr. 42"
7605
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Cerebral Dystocia
DUE TO (c): Tight cord loop around neck x1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 5/17, 1966, to 5/17, 1966, that (I) (we) last saw the deceased alive on 5/17 1966, and that death occurred at 3:32 p.m., from the causes and on the date stated above.

22a. SIGNATURE: D. G. Anderson, M.D. M.D. ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 5/17/66
22c. PHYSICIAN'S NAME (Type): D. G. ANDERSON
22d. ADDRESS: SALISBURY, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE THEREOF: MAY 19, 1966
23c. NAME OF CEMETERY OR CREMATORY: BLADES CEMETERY
23d. LOCATION (City, town or county) (State): BLADES DELAWARE
24. FUNERAL DIRECTOR: Kenneth M. Watson — ADDRESS: SEAFORD, DEL.
25a. REC'D BY REGISTRAR DATE: MAY 20 1966
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

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20M 1/65

6-220319

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

07734 07724

1. PLACE OF DEATH
a. COUNTY: Wicomico
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b: Adm in 1-D 5/7/66
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Pen.Gen.Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 22-1
d. STREET ADDRESS: 105 West Phila,Ave. e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CARRIE Middle JAMES Last SULLIVAN

4. DATE OF DEATH: Month MAY Day 7th Year 1966

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 7/1905

9. AGE (In years last birthday): 61 yrs. IF UNDER 1 YEAR: Months 1 Days 0 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House wife

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Delmar Delaware

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Hearn

14. MOTHER'S MAIDEN NAME: Ida Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 213-14-6134

17. INFORMANT: Mr.Herman L.Sullivan (Husband) Address: 105 West Philadelphia Ave. Salisbury, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion with Myocardial Infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): 4201
DUE TO (c): Arteriosclerotic Heart Disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): N/A

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Apr 4 19 15P M. to ____, 19__, that (I) (we) last saw the deceased alive on ____ 19__, and that death occurred at ____ M, from the causes and on the date stated above.

22a. SIGNATURE: Thomas C Hill Jr. M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: May 8 /1966

22c. PHYSICIAN'S NAME (Type): Dr. Thomas C.Hill

22d. ADDRESS: Pine Bluff Road Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 10/1966

23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

23d. LOCATION (City, town or county) (State): Salisbury, Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY ADDRESS: SALISBURYMARYLAND

25a. REC'D BY REGISTRAR DATE: MAY 12 1966

25b. REGISTRAR'S SIGNATURE: J Charles Judge

VR A15 (4)
20M 1/65

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# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07735 Item 8 film G376 5/23/66 07725

1. PLACE OF DEATH
a. COUNTY: WICOMICO
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: SOMERSET
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): PRINCESS ANNE
d. STREET ADDRESS: R.F.D. 1
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| HERMAN | CHARLES | TAYLOR | MAY | 15 | 1966 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR Months / Days | IF UNDER 24 HRS. Hours / Min. |
|---|---|---|---|---|---|---|
| MALE | WHITE | | SEPT. 19, 1908 | 57 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| FARMER | FARMING | PRINCESS ANNE, MD. | U.S.A. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| ROBERT TARLOR | ROSA TAYLOR |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | | MRS LOTTIE TAYLOR PRINCESS ANNE, MD. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Polyarteritis nodosa — INTERVAL BETWEEN ONSET AND DEATH 18 mos.
456 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work [ ] Not While at work [ ] | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|---|---|---|
| | | | |

21. I certify that (I) ~~(this hospital)~~ attended the deceased from 4-22, 1966, to 5-13, 1966, that (I) ~~(we)~~ last saw the deceased alive on 5-14 1966, and that death occurred at 1:35 P.M., from the causes and on the date stated above.

| 22a. SIGNATURE | M.D. | ATTENDING PHYS. [X] | MED. DIRECTOR [ ] | STAFF PHYS. [ ] | 22b. DATE SIGNED |
|---|---|---|---|---|---|
| Robert R. Thute, Jr. | | | | | |

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) |
|---|---|---|---|
| BURIAL | 5/18/1966 | ALLEN CEMETERY | ALLEN, MARYLAND |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| LEVIN R. WILSON PRINCESS ANNE, MD. | MAY 19 1966 | J. Charles Judge |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07736

## CERTIFICATE OF DEATH

07726

1. PLACE OF DEATH
   a. COUNTY: Wicomico
   MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b: 40 Days
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Deer's Head State Hospital, Salisbury, Md.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Queen Anne's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Centreville
   d. STREET ADDRESS: Rt. 2, Box 121-A
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Blanche; Middle: Ella; Last: Teat

4. DATE OF DEATH: Month: May; Day: 9; Year: 1966

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 6, 1893

9. AGE (In years last birthday): 70 yrs.
   IF UNDER 1 YEAR: Months; Days
   IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Centreville, Queen Anne's

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: Laura Kirby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO.: 219-07-7137

17. INFORMANT: Josiah Teat Address: Centreville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

4201
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arteriosclerotic cardiovascular disease — Years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year; Hour a.m. p.m.; 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 3/30, 1966, to 5/9, 1966, that (I) (we) last saw the deceased alive on 5/9, 1966, and that death occurred at 2:35 M, from the causes and on the date stated above.

22a. SIGNATURE: W. Maldve, M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑

22b. DATE SIGNED: 5/10/66

22c. PHYSICIAN'S NAME (Type): L. V. Maldve, M. D.

22d. ADDRESS: Deer's Head State Hospital, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5-13-66

23c. NAME OF CEMETERY OR CREMATORY: Bunerelle Mem

23d. LOCATION (City, town or county): Centerville (State): Md.

24. FUNERAL DIRECTOR: James B. Hashed ADDRESS: Easton, Md.

25a. REC'D BY REGISTRAR DATE: MAY 16 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15 (4)
20M 1/65

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FOR STATE HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

07737

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07727

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Railroad Ave.(Pa.Railroad Bldg)

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
   d. STREET ADDRESS: Camden Ave.Ext
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First OTIS — Middle DASHIELL — Last THOMAS

4. DATE OF DEATH: Sun — Month MAY — Day 15th — Year 1966

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 8/1903

9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months 11, Days 07 — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Employee-Guard-Frozen Food Plant

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Somerset Co., Maryland

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: William James Thomas

14. MOTHER'S MAIDEN NAME: Nellie Dashiell

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
   (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 220-10-8272

17. INFORMANT: Mrs.Irma K.Thomas(Wife) — Address: P.O.B.#92 Fruitland, Maryland

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: Sudden

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☑, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): Dr.Earl L.Royer

Address (Street, city, town, or county): 409 Camden Ave.Salisbury,Md.

22. DATE SIGNED: May 16 /1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: May 17/1966

23c. NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park

23d. LOCATION (City, town or county) (State): Salisbury,Maryland

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY,MARYLAND

25a. REC'D BY REGISTRAR: MAY 17 1966

25b. REGISTRAR'S SIGNATURE: J.Charles Judge

VR AISME (5) 5M 1/65

Memorial Park

1

**FOR STATE HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

07738

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07728

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Jesterville
   c. LENGTH OF STAY IN 1b: lifetime
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Wicomico
   c. CITY OR TOWN (If outside carporate limits, write RURAL and give nearest town): Jesterville 22.1
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First LEVIN — Middle RODNEY — Last TURNER

4. **DATE OF DEATH**: Month 5-9-66 — Day — Year 19

5. SEX: Male

6. COLOR OR RACE: AA

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1/10/1887

9. AGE (In years last birthday): 79 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Rufus Turner

14. MOTHER'S MAIDEN NAME: Susan Dashield

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT — Address: Lillian Turner, Jesterville, Md.

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
4201

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a.m. p.m. — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Earl L. Royer M.D.

EXAMINER'S NAME (Type): Earl L. Royer, M.D.

Address (Street, city, town, or county): 409 Camden Ave., Salisbury, Md.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22. DATE SIGNED: May 10, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 5/15/66

23c. NAME OF CEMETERY OR CREMATORY: Jesterville Cem.

23d. LOCATION (City or Town) (County) (State): Jesterville, Wicomico, Md.

24. FUNERAL DIRECTOR — ADDRESS: C. Mossie, Bivalve, Md.

25a. REC'D BY REGISTRAR — DATE: MAY 12 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

VR A15ME (5)
6M 1/66

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

07739 07729

1. **PLACE OF DEATH**
   a. COUNTY: Wicomico — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Peninsula General Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: Kent
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Galena
   d. STREET ADDRESS: 14-2
   e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. **NAME OF DECEASED** (Type or print): First DAVID — Middle H. — Last WALTERS

4. **DATE OF DEATH**: Month 5 — Day 18 — Year 66

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: 11-18-46

9. AGE (In years last birthday): 19 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Addie H. Walters.

14. MOTHER'S MAIDEN NAME: Clara Virginia Davis.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No.

16. SOCIAL SECURITY NO.: 216-48-6048

17. **INFORMANT**: Addie H. Walters, — Address: Galena, Md. 21635

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Crushed chest and abdomen — INTERVAL BETWEEN ONSET AND DEATH: one hour
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. EXTERNAL CAUSE WAS PRIMARY [X] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
Driver of auto which collided with another vehicle.

20c. TIME OF INJURY Month, Day, Year Hour o.m.: 10:10 5-18-66

20d. INJURY OCCURRED While at work [ ] Not While at work [X]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 50 & 113

20f. (City or town) (County) (State): Worcester, Md.

21. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [ ], Accident [X], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type): Earl L. Royer, M.D.
409 Camden Ave., Salisbury, Md.

M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
Address (Street, city, town, or county)

22. DATE SIGNED: May 19, 1966

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: May, 21, 1966
23c. NAME OF CEMETERY OR CREMATORY: Galena Cemetery
23d. LOCATION (City or Town) (County) (State): Galena, Kent Co; Md.

24. FUNERAL DIRECTOR: Edward Fellows
ADDRESS: Millington, Md.

25a. REC'D BY REGISTRAR DATE: MAY 24 1966

25b. REGISTRAR'S SIGNATURE: J. Charles Judge

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07740 07730

1. PLACE OF DEATH
a. COUNTY Wicomico MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN 1b Adm in ED 5/2/66
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) P.G. Hospt.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland, 22-1
d. STREET ADDRESS Main Street,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Lyda Middle: Roberta Last: Wheatley
4. DATE OF DEATH Month: May Day: 6. Year: 19 66.
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH Jan.20.1888.
9. AGE (In years last birthday) 78 yrs. IF UNDER 1 YEAR Months 5 Days 18 IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife
10b. KIND OF BUSINESS OR INDUSTRY At Home
11. BIRTHPLACE (County & State, or foreign country) Marion Station, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob Townsend
14. MOTHER'S MAIDEN NAME Emily Adams
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No (If yes give war or dates of service)
16. SOCIAL SECURITY NO. 288 20 7520
17. INFORMANT Address Mr. Graydon H. Mezick Fruitland, Maryland.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Anemia & uraemia
171 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Ca Cx stage IV
DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Oct, 1965 to May 6, 1966, 1966, that (I) (we) last saw the deceased alive on May 6 1966, and that death occurred at 5.15 a.m. p.m. from the causes and on the date stated above.

22a. SIGNATURE Stedman W. Smith M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED 5/9/66
22c. PHYSICIAN'S NAME (Type) Stedman W. Smith
22d. ADDRESS Salisbury, Maryland.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF May8.1966.
23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park.
23d. LOCATION (City, town or county) (State) Salisbury, Maryland.

24. FUNERAL DIRECTOR ADDRESS Holloway & Co. Salisbury, Maryland.
25a. REC'D BY REGISTRAR DATE MAY 10 1966
25b. REGISTRAR'S SIGNATURE J Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07741 07731

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: WICOMICO
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SALISBURY
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): PENINSULA GENERAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: WICOMICO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): MARDELA 22-1
d. STREET ADDRESS: R.F.D.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First EDWINA Middle — Last WHITE

4. DATE OF DEATH: Month MAY Day 24, Year 1966

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 10-19-1887

9. AGE (In years last birthday): 78 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AT HOME

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: THOMAS J. BRADLEY

14. MOTHER'S MAIDEN NAME: IDA MAE WOOLEN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: MARY WHITE - MARDELA MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Bronchopneumonia with Effusion — INTERVAL BETWEEN ONSET AND DEATH

491X

Conditions, If any, which gave rise to Immediate cause (a), stating the underlying cause last.

DUE TO (b): —

DUE TO (c): —

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Arteriosclerotic Heart Disease with passive Congestion

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) ~~(this hospital)~~ attended the deceased from May 23, 1966, to May 24, 1966, that (I) ~~(we)~~ last saw the deceased alive on May 24 1966, and that death occurred at 2:25 M, from the causes and on the date stated above.

22a. SIGNATURE: Thomas C. Hill Jr., M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: May 24, 1966

22c. PHYSICIAN'S NAME (Type):

22d. ADDRESS:

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 5-27-66

23c. NAME OF CEMETERY OR ~~CREMATORY~~: RIVERTON

23d. LOCATION (City, town or county) (State): RIVERTON MD

24. FUNERAL DIRECTOR ADDRESS: Charles W. Hearn - Delmar, Del

25a. REC'D BY REGISTRAR DATE: MAY 26 1966

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4) 20M 1/65

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
## CERTIFICATE OF DEATH

07742 — 07732

**1. PLACE OF DEATH**
a. COUNTY: Wicomico — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Peninsula General Hospital

**2. USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Md. — b. COUNTY: Somerset
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Princess Anne — 19-2
d. STREET ADDRESS: S. Somerset Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

| 3. NAME OF DECEASED (Type or print) First | Middle | Last | 4. DATE OF DEATH Month | Day | Year |
|---|---|---|---|---|---|
| William | R | Wilson | May | 6 | 1966 |

| 5. SEX | 6. COLOR OR RACE | 7. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 8. DATE OF BIRTH | 9. AGE (In years last birthday) | IF UNDER 1 YEAR: Months / Days | IF UNDER 24 HRS.: Hours / Min. |
|---|---|---|---|---|---|---|
| Male | White | ☒ / ☐ / ☐ / ☐ | May 8, 1892 | 73 yrs. | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (County & State, or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Salesman | | Somerset Co., Md. | U.S. |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| George W. Wilson | Mamie Nutter |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) | (If yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| yes | War I | 216-05-7626 | Mrs. Sue Wilson, Princess Anne, Md. |

**MEDICAL CERTIFICATION**

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary Edema. — INTERVAL BETWEEN ONSET AND DEATH: 3 hours.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Left ventricular failure. — 2 yrs.
DUE TO (c): Hypertensive Arteriosclerotic C.V. Disease — Years.

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Severe emphysema secondary to chronic bronchitis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

| 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 | 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
|---|---|---|---|
| | | | |

21. I certify that (I) (this hospital) attended the deceased from 5/5, 1966 to 5/6, 1966, that (I) (we) last saw the deceased alive on 5/5/1966, and that death occurred at 2158 M, from the causes and on the date stated above.

22a. SIGNATURE — M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type) — 22d. ADDRESS

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City, town or county) (State) |
|---|---|---|---|
| Burial | 5/8/1966 | St. Andrew | Princess Anne, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James L. Lerman — Princess Anne, Md. | MAY 10 1966 | J. Charles Judge |

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